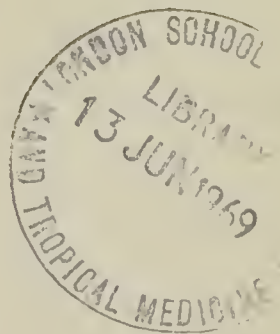


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CUMBERLAND COUNTY COUNCIL

THE HEALTH OF CUMBERLAND 1968

REPORT OF THE
COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

A N N U A L R E P O R T

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1968

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,

M.R.C.S., L.R.C.P., D.P.H.,

County Medical Officer.

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PREFACE

To the Chairman and Members of the County Council :

I have the honour to present my Annual Report for the year 1968 on the health of the Cumbrian.

I would like to draw attention to some of the facts that appear in the chapter dealing with vital statistics.

The population of the county remains almost static but there is an increase of some 400 elderly within this figure. Indeed here the elderly are the only group increasing in numbers, causing increasing use of the heavily committed medical and welfare services.

The birth rate for the year is the lowest ever recorded. It is pleasing to see that the peri-natal death rate—the most sensitive index of the effectiveness of the maternity and indeed the medical services as a whole—is the lowest ever recorded in the county; and also to note that the year was one in which no mother from the county lost her life during, or on account of, childbirth. This most happy state of affairs is but a reflection in figures of the increasing integration of the maternity and paediatric services both in family medicine and under the respective hospital departments and consultants. It augurs well for the future.

With an almost static death rate of 12.4 per 1,000 population and the lowest birth rate of 15.1 per 1,000 population, the natural increase (the difference in these rates) has also been the lowest recorded. A low natural increase in association with a high rate of outward migration is not a good omen for the county's future. This spiral can only be arrested by the allocation of more industry with associated job opportunities to replace the old basic industries of West Cumberland.

The vital statistics reflect the present state of the medical and welfare services as a whole, and I am happy to report that the Council's policy of integration of all field staff of the Health and Welfare Department into family doctor led health care teams has been fully justified. I feel that professional job satisfaction has been greatly increased and, whilst the effectiveness has in-

creased, the sense of frustration and inadequacy consequent upon the isolation of individual effort has diminished. No longer can it be said that general practice is a "cottage industry" in this county—the practitioner is becoming more and more a chairman of a working party dealing with his patients' welfare whilst remaining in sole charge of the diagnostic and therapeutic aspects of his patients' illness.

In addition to the change that community medicine has undergone, links with all the hospitals in the administrative county have been further strengthened. The speed of change is increasing and this thought is confirmed by the realisation that in my last report I was thinking in terms of community and hospital medicine whereas this year the thinking both in the department and elsewhere is that medicine can only be thought of in terms of unity. Not only must it appear so to the individual patient but, as far as it can under current legislation, it is becoming a functional unity in this county. More and more cases from all wards in our hospital are being discharged as part of a planned continuous care scheme where the family health care team takes over the patient care in the home. Is this really to be wondered at since already these teams care for over 99% of the population at any given time?

The present position of the services shows some interesting new developments. Health visiting is becoming even more selective and a start has been made to a practice based preventive geriatric service. Surgery nursing already accounts for about 10% of the nursing service provided in the community, whilst home nursing is at the highest level ever recorded in any year. For reasons given in this report, domiciliary midwifery is now not a viable proposition with less than eight mothers in every hundred being confined at home. In order to give the best service, the two hospital management committees have been asked to act as the authority agents to provide midwives to care for confinements in the home. Meanwhile, it is hoped and expected that the domiciliary midwife may become a part-time community based worker and an expert together with the general practitioner obstetrician, in ante-natal and post-natal care of the mother and child, in the early developmental progress of the child.

The loyalty and sincerity of all nurses, health visitors, midwives and social workers, in these years of such change is to be commended, and the way in which they so unselfishly devote their professional skills to the patients or clients is a lesson to the community.

What a year it has been for new thinking and preparation for new action. The National Health Service has been functioning in this country for over twenty-one years—its majority was celebrated with a conference in London in July—and many now feel that as a quarter of a century has elapsed from its inception this might be a suitable time to change over to a new and more effective pattern of work. No longer do I see curative and preventive medicine as separate parts of medicine; no longer do I see the need to continue the present separatist system which is so costly in terms of precious manpower. There is need for the unity of medicine as a total profession and this is being accepted generally. The difficulties lie in the type of administrative organisation under which Health will function and the Green Paper gave the opportunity for wide ranging discussion on these matters to take place.

At the same time the Seeborn Committee on local authority social workers and allied staff recommended an amalgamation of all present social work being carried out in Children's, Education, Health, Housing and Welfare Departments to form a local authority Family Welfare Department under a professional head.

What is equally important is the Todd Report on Medical Education fore-shadowing great changes in hospital and community medicine and giving some hint of the work in future years of the Medical Officer of Health who, by that time, will have taken the new name of Community Physician. As today this doctor's work will centre on population rather than patient medicine; he it will be who will assess the total medical needs of his community and, having done so, will help to organise medicine to meet them. The main difference from today's Medical Officer of Health is that there will be full financial and statutory backing

to his work. I find that further non-statutory progressive steps in community medicine are becoming harder to take and the only solution is an administrative re-organisation.

An important part of the picture of medicine in the last quarter of the twentieth century is still not defined—the nature of local government. We await the Royal Commission's report with some eagerness, and, whilst appreciating the trends towards larger and more effective units, look forward to a continuation of democratic participation in decision taking.

Lastly, how might the health of the Cumbria be improved? Less excessive cigarette smoking, weight reduction where advised by the personal physician and the taking of more active exercise would help to reduce the toll of heart disease which carries off so many—especially men with young families—in this northern county. It has been assessed that cigarettes cause not less than seven times as many deaths every year as do road accidents.

In a year of such accomplishment in health and welfare matters as the following pages will, I hope, clearly show to the reader, it is particularly pleasant to record the continued involvement of the community and particularly of the youth of Cumberland in the problems of the handicapped of all ages, including those with mental handicap. It has been a great stimulus to all the professional workers and long may this fierce idealism continue—it foretells a brighter future.

My thanks go out to my medical and nursing colleagues for their help and advice, and to the administrators and clerical officers in the Health and Welfare Department for their loyal co-operation—the early publication of this report is tangible proof of their efficiency. To the Clerk of the County Council, the County Treasurer, and my fellow chief officers, I am indebted for their helpful co-operation.

To the Chairman of the Health Committee go my thanks for
her continued support and wise advice during the year.

I have the honour to be Sir,

Your obedient Servant,

John Leiper.

County Medical Officer of Health.

County Health Department,
11 Portland Square,
Carlisle.
Telephone — Carlisle 23456.



STAFF

County Medical Officer and County Welfare Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Area Medical Officers—

C. A. Bentley, B.A., M.R.C.S., L.R.C.P., D.P.H., Northern Area Medical Officer; Medical Officer of Health to Border Rural District.

J. L. Hunter, M.B., Ch.B., D.P.H. Western Area Medical Officer; Medical Officer of Health, Workington Borough.

S. Smith, M.B., Ch.B., D.P.H., Southern Area Medical Officer; Medical Officer of Health, Whitehaven Borough and Ennerdale Rural District.

Assistant County Medical Officers—

J. E. Ainsworth, M.B., Ch.B.

E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. and H., (Also Medical Officer of Health, Maryport Urban District).

J. E. M. Garland, M.B., Ch.B., D.P.H., (Also Medical Officer of Health, Wigton Rural District).

A. Hargreaves, M.B., Ch.B., D.P.H. (Deputy Western Area Medical Officer, Medical Officer of Health, Cockermouth Rural and Urban Districts, Keswick Urban District).

J. R. Hassan, M.B., Ch.B., D.Obst., R.C.O.G. (Also Medical Officer of Health, Alston Rural District and General Practitioner).

H. M. Marks, M.B., Ch.B.

M. Timperley, M.B., Ch.B., D.C.H.

K. R. Walker, M.B., Ch.B.

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Western Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

J. Colvin, L.D.S.R.F.P.S.

A. B. Gibson, B.D.S.

F. H. Jacobs, L.D.S.

I. H. Parsons, L.D.S.

A. R. Peck, L.D.S.

A. M. Scott, L.D.S.

Welfare Services Officer—

N. Froggatt.

Deputy Welfare Services Officer—

I. Duthie, C.S.W., D.P.A.

Social Welfare Officers—

Northern Area

Miss E. A. Welch, A.A.P.S.W., Senior Welfare Officer
M. Steels

I. H. Moffet, C.S.W.

M. H. Payne

G. A. H. Miller.

W. H. Robinson (part-time).

Western Area

Miss E. F. Hall, Senior Welfare Officer
B. Reeves.

A. Davidson, R.M.N., S.R.N., C.S.W.

A. Irving.

T. Hetherington.

Miss R. J. Pugsley, C.S.W.

Southern Area

J. M. Ruddick, C.S.W., Senior Welfare Officer.
J. Allison, C.S.W.
R. Daley.
Miss L. O'Hare, C.S.W.
Miss C. Marshall, Welfare Assistant.

Patrons of Residential Accommodation—

Mr. W. L. Anderson, S.R.N., Q.N., Alneburgh House,
Maryport.
Mrs. M. Beresford, Grisedale Croft, Alston.
Mrs. M. Campbell, Castle Mount, Egremont.
Mr. E. McKinney, Fairview Hostel, Bransty, Whitehaven.
Mrs. N. Johnson, Richmond Park, Workington.
Mrs. P. D. Fitz, The Croft, Kirksanton.
Miss B. Edgar, Grange Bank, Wigton.
Mrs. M. M. Guy, S.R.N., Highfield House, Wigton.
Mrs. A. Hill, S.R.N., Greengarth, Penrith.
Mrs. M. Melville, Moot Lodge, Brampton.
Mrs. H. J. Milnes, Derwent Lodge, Papcastle.
Miss A. G. Ross, S.R.N., Parkside, Maryport.
Miss A. D. Wright, Garlieston, Whitehaven.
Mrs. R. Wilson, S.R.N., Brackenthwaite, Whitehaven.
Miss V. Woodman, S.R.N., The Towers, Skinburness.
Miss E. McCormick, Park Lodge, Aspatria.
Mrs. D. J. Crew, S.E.N., Eskdale House, Longtown.

Home Teachers for the Blind—

Miss J. Burgess.
Miss L. D. Fraser.
Mrs. G. Mossop.
Miss M. Shuttleworth.

Training Centre Supervisors—

J. J. Lace, Dip.N.A.M.H., Adult Training Centre, Distington.
Miss A. Love, Dip.N.A.M.H., Dip.T.C.T.M.H., Junior Training
Centre, Whitehaven.
Miss G. L. Lister, Dip.N.A.M.H., Dip.T.C.T.M.H., S.E.N.,
Junior Training Centre, Wigton.

Consultant Psychiatrists (part-time) seconded from Newcastle Upon Tyne Regional Hospital Board—

T. R. Burgess, M.R.C.S., L.R.C.P., D.P.M.

T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

Chief Nursing Officer—

Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N., H.V.Cert.

Deputy Chief Nursing Officer—

Miss K. J. Hayes, S.R.N., S.C.M., H.V. Cert.

Area Nursing Officers—

Miss J. M. Crossfield, S.R.N., Q.N., H.V.Cert., Western Area

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert., Southern Area

Mrs. J. M. Roberts, S.R.N., S.C.M., H.V.Cert., Q.N., Northern Area.

Audiometricians—

Mrs. J. Laidlow

Miss A. Jackson

Miss D. Kidd

Chiropodists—

G. H. Thomas, M.Ch.S., S.R.Ch.

W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N.

R. J. Cowan, R.M.N., S.R.Ch.

Mrs. D. E. Smart, M.I.C.Ch., S.R.Ch.

Mrs. G. Garrett, M.Ch.S., S.R.Ch.

Mrs J. Glaister, M.Ch.S., S.R.Ch.

Orthoptists—

Miss J. A. M. Davies, D.B.O.

Mrs. J. Scott, D.B.O. (Part-time).

Physiotherapists—

Mrs. P. P. Bratt, M.C.S.P. (Part-time).

Miss M. Sivewright, M.C.S.P. (Part-time).

Speech Therapists—

Mrs. E. M. Blacklock, L.C.S.T.

Miss E. B. Moon, L.C.S.T. (Part-time).

Mrs. S. Latimer, L.C.S.T. (Part-time).

Mrs. J. Stone, L.C.S.T. (Part-time).

County Ambulance Officer—

M. F. Smith, F.I.A.O.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

FAMILY HEALTH CARE TEAMS DECEMBER, 1968

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. R. Hassan Dr. R. F. Master, Alston	Mrs. E. M. Walton Mrs. A. Davidson Mrs. P. E. White (Relief).	Mrs. E. M. Walton	Miss E. A. Lockhart
Dr. A. M. Rankin Dr. E. Rankin, Aspatria.	Miss J. Higginbottom Mrs. J. Dickinson (Relief)	Miss J. Higginbottom	Miss C. M. Bannan
Dr. A. C. Beeby Aspatria	Miss J. Higginbottom	Miss J. Higginbottom	Miss C. M. Bannan
Dr. J. B. Fox, Aspatria	Miss J. Higginbottom	Miss J. Higginbottom	Miss C. M. Bannan
Dr. H. P. Nelson Dr. W. J. Lush Dr. R. E. D. Nelson Dr. J. C. Burn Dr. I. J. Clark Brampton	Miss B. M. Wesson Mrs. F. Gaskin Mrs. E. A. Leddy Mrs. K. M. Bell (Relief) Mrs. A. Gallacher (Relief)	Mrs. F. M. Hurst	Miss E. Tongue Miss B. Knibbs
Dr. M. I. Cox Caldbeck	Miss A. Bowler Mrs. G. J. Howat (Relief)	Miss A. Bowler	Miss A. Bowler
Dr. W. P. Hayne Dr. H. J. Bradley Dalston	Mrs. M. E. Wilde Mrs. M. Thom (Relief)	Mrs. M. E. Wilde Mrs. M. Thom	Miss P. B. Simpson
Dr. N. W. Cameron High Hesketh	Miss J. R. N. Byres	Miss J. R. N. Byres	Mrs. D. Edmondson
Dr. N. C. F. Milne Kirkoswald	Miss J. R. N. Byres	Miss J. R. N. Byres	Mrs. M. McCredie

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. D. A. McDonald	Miss A. A. Cockton	Miss A. A. Cockton	Mrs. A. E. Henderson
Dr. R. A. Maxwell Kirkbride	Mrs. P. A. Drysdale (Relief)		
Dr. R. A. Forrester Longtown	Miss V. Dodgson Mrs. F. M. Hurst	Miss V. Dodgson Mrs. F. M. Hurst	Miss M. Butler
Dr. G. M. Ingal Longtown	Miss V. Dodgson Mrs. F. M. Hurst Mrs. E. Harper (Relief)	Miss V. Dodgson Mrs. F. M. Hurst	Miss M. Butler
Dr. F. C. Edington	Mrs. E. J. Relph	Mrs. G. Nixon	Miss A. M. Murray
Dr. H. C. Barr	Mrs. G. Nixon		
Dr. I. M. Johnstone	Mrs. M. Judson (Relief)		
Dr. G. F. Lewis Penrith	Mrs. M. Jackson (Relief)		
Dr. G. H. Kilgour	Mrs. I. Penn	Mrs. I. Penn	Mrs. W. Davison
Dr. C. H. Thomson Penrith	Mrs. P. Coulthard (Relief)		
Dr. K. Todd	Miss K. Winter	Miss K. Winter	Miss I. Arnott
Dr. J. B. Scott	Mrs. E. Plant		
Dr. I. O. Miller Penrith	Mrs. M. M. Barnard (Relief)		
Dr. H. Hutton	Miss G. Jobson	Miss G. Jobson	Mrs. M. D. Dixon
Dr. R. M. Yule Silloth	Mrs. D. Poole (Relief)		
Dr. W. Hetherington	Miss M. Weightman	Mrs. M. Dobson	Miss E. A. Lockhart
Dr. D. A. Nisbet Wetheral	Mrs. F. E. Yeomans (Relief)		
Dr. T. M. Dolan	Mrs. D. Lancaster	Mrs. D. Lancaster	Miss E. Mercer
Dr. G. A. H. Jones	Mrs. M. Hope		
Dr. N. Gray Wigton	Miss M. Jones (Relief)		

HEALTH VISITORS		VISITORS	
Dr. K. Gillow	Mrs. E. M. Stafford	Mrs. M. Dobson	Mrs. M. Dobson
Dr. T. Mooney			
Dr. T. Gardner			
Dr. G. Raitt			
Dr. J. F. McKellican			
Dr. A. Backman			
Carlisle			
Dr. G. M. Jolly	Mrs. J. A. Branthwaite	Mrs. M. Dobson	Mrs. M. Dobson
Dr. W. C. Menzies	Mrs. F. E. Yeomans (Relief)		
Dr. W. P. Honeyman			
Dr. N. C. Frame			
Carlisle,			
Dr. J. D. Ogilvie	Mrs. M. J. Mathews	Mrs. M. J. Mathews	
Glenridding,	Mrs. D. M. Scoon (Relief)		
North Westmorland			
Dr. D. M. C. Ainscow	Mrs. V. Lamb	Mrs. I. Penn	Mrs. W. Davison
Temple Sowerby	Miss J. M. Byers (Relief)		

SOUTHERN AREA

FAMILY HEALTH CARE TEAMS

DECEMBER, 1968

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. H. Calder	Miss J. A. G. Hardie	Miss J. A. G. Hardie	Miss J. A. G. Hardie
Dr. J. Sharp	Mrs. N. Wilkinson		
Distington	Mrs. V. Moore (Relief)		
Dr. W. R. Hunter	Mrs. V. Wrightson	Mrs. V. Wrightson	Miss M. E. Gibson
Dr. J. N. Edgley	Mrs. M. T. Toole	Miss E. M. Miller	Miss R. Sheppard
Dr. J. Veitch			
Egremont			
Dr. E. Braithwaite	Mrs. A. Gell	Mrs. V. Wrightson	Mrs. A. Gell
Dr. J. W. Strain	Mrs. D. Adair (Relief)		
Egremont and Cleator			
Dr. A. S. Smith	Mrs. F. Corkhill	Mrs. V. Wrightson	Miss E. Crosby
Dr. L. Henry	Mrs. M. Wightman		
Egremont and	Mrs. A. Rea (Relief)		
Cleator Moor			
Dr. W. G. McKay	Miss H. Spencer	Miss M. Proctor	Miss P. Walsh
Dr. C. Donald	Mrs. J. Niles (Relief)		
Dr. H. E. Johnston			
Frizington			
Dr. A. E. Jackson	Miss M. G. Beattie	Miss M. G. Beattie	Mrs. I. E. Bowe
Dr. M. J. Leverton	Mrs. I. Booth	Mrs. I. Booth	Mrs. A. Donald
Dr. P. M. Taylor	Mrs. M. K. Wilson		
Dr. A. E. Todd	Mrs. S. E. Troll		
Millom	Mrs. B. Bawden		
	(Surgery Nurse)		
	Mrs. M. J. Fazakerley (Relief)		

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. J. Louden	Miss D. D. James	Miss D. D. James	Miss D. D. James
Dr. J. W. Jago	Mrs. E. Speed-Andrews	Mrs. M. Marshall	Mrs. M. Marshall
Dr. J. M. Kirk	Mrs. J. A. Capp		Mrs. A. W. Lynn
Dr. A. M. Smith Seascale	Mrs. E. Gallantry		
	Mrs. M. Marshall		
	Mrs. A. W. Lynn		
	Mrs. A. G. Holmes (Relief)		
	Mrs. I. Smith (Relief)		
Dr. M. C. Nicolson	Mrs. I. Routledge	Mrs. M. Ainsworth	Mrs. S. Crellin
Dr. R. N. Galloway	Mrs. H. Egan		
Dr. B. T. Higgins	Mrs. A. Keanan		
Dr. R. H. Pearson Whitehaven	Mrs. B. Tinnion (Relief)		
Dr. R. W. Chalmers	Mrs. M. West	Mrs. M. Ainsworth	Miss I. M. Alcock
Dr. A. P. Timney Whitehaven			
Dr. J. Gilmour	Mrs. M. Swinburne	Mrs. M. Ainsworth	Miss I. M. Alcock
Dr. B. Moss Whitehaven			
Dr. H. A. Fleming	Miss J. Woodend	Mrs. M. Ainsworth	Miss A. Singleton
Dr. J. G. Dickson			
Dr. E. Graham Whitehaven			
Dr. N. L. Burrell	Mrs. E. Brannan	Mrs. M. Ainsworth	Mrs. A. Petch
Dr. R. C. McFarlane Whitehaven			
	Mr. R. Holt—Male Nurse—Works with ALL	Whitehaven Practices	

WESTERN AREA

FAMILY HEALTH CARE TEAMS DECEMBER, 1968

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. T. Fletcher	Miss A. I. Kirk	Miss A. Kirk	Mrs. M. Lythgoe
Dr. E. B. Herd	Miss M. Musgrave	Miss M. Musgrave	Miss A. Dixon
Dr. M. G. Porteous Cockermouth	Mrs. V. Sherwood		
	Mrs. E. Swindle (Relief)		
Dr. A. G. Abraham Cockermouth	Mrs. K. Lytollis	Miss A. Kirk	Miss M. Reynolds
Dr. R. J. M. Irvine Cockermouth	Mrs. M. E. Dobson (Relief)	Miss M. Musgrave	Miss M. Reynolds
	Mrs. J. V. Clark	Mrs. J. V. Clark	
Dr. J. A. Harrow Keswick	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. Mitchell Keswick	Mrs. A. B. Pearson	Mrs. A. B. Pearson	Miss M. Casey
Dr. T. Donaldson Keswick	Mrs. M. J. Cox (Relief)		
	Mrs. J. E. Barnes	Mrs. A. B. Pearson	Mrs. A. E. Campbell
Dr. I. F. Smith Keswick	Miss S. M. J. Iliffe	Miss S. M. J. Iliffe	Mrs. A. E. Campbell
Dr. J. D. H. Bird	Miss A. Chadwick	Miss O. Pickering	Miss S. Twigg
Dr. S. A. W. Rattie	Miss O. Pickering	Miss A. Chadwick	Mrs. M. Hedworth
Dr. K. Longstaff	Mrs. C. M. Gate	Mrs. C. M. Gate	
Dr. B. J. Havard	Mrs. A. Irving		
Dr. F. W. Clark	Mrs. M. Robinson		
Dr. C. M. Yule Maryport			

General Practitioners	Home Nurses	Midwives	Health Visitors
Dr. R. E. Fletcher	Mrs. J. Palin	Miss J. Cunliffe	Miss A. Jackson
Dr. R. H. Fletcher	Mrs. L. Daniels (Relief)		
Dr. W. H. Fletcher			
Dr. A. Craig Workington			
Dr. D. N. Fitzgerald Workington	Mrs. M. I. Lewis) Mrs. D. Fisher (Relief))		Mrs. M. Hewitson
Dr. N. McKerrow	Miss M. Young)		Miss E. J. Surtees
Dr. P. I. Rutherford	Mrs. J. M. Brown)		Mrs. J. A. Graham
Dr. M. O. Sime Workington	Mrs. M. K. Tunstall)		
Dr. J. Pavey-Smith	Mrs. M. Hamilton)		Mrs. B. L. Goodson
Dr. I. R. McLeod Workington	Mrs. L. Messenger) Mrs. M. Mitchell (Relief))		
Dr. C. Robinson	Mrs. P. Holdsworth)	Miss J. Cunliffe	Miss F. Davies
Dr. J. Prentice	Mrs. J. M. Potts)	Mrs. F. T. Ashworth (Relief)	
Dr. R. F. Longdin Workington			
Dr. G. M. Thomas Workington	Mrs. M. I. Lewis) Mrs. D. Fisher (Relief))		Mrs. D. R. Bari
Dr. R. N. R. Grant Workington	Mr. M. I. Lewis) Mrs. D. Fisher (Relief)) Mr. T. O. M. Holmes, Male Nurse) Mr. T. G. Carter, Male Nurse) Mrs. M. B. White)		Mrs. D. R. Bari
		Work with all Workington Practices	

ADMINISTRATION

Because the County Council's offices are not geographically centrally placed in the administrative county and because of the increase in the amount and nature of the service provided, the aim for some time has been the decentralisation of the day to day administration of the health and welfare services. Indeed, looking back five years to central administration it is difficult to imagine how effective supervision and control was exercised in places up to 75 miles away from the office. I would say that since the time the authority decided to decentralise, the development of community care would have proved an extremely difficult task—and probably more expensive—had no change been made.

The day-by-day management of practically all aspects of the health and welfare services (the only significant exceptions being the ambulance and dental services) is delegated to the three Area Medical Officers, who are each responsible to an Area Health Sub-Committee. These sub-committees have a wide representation, including amongst their members hospital consultants, general practitioners, teachers and representatives of district councils. Each of the areas has a population of around 75,000 and it is interesting to see that this is the size of area which the Seebohm Committee considered appropriate for area administration.

In addition to receiving the reports of these Area Committees, the parent committee receives reports from the Joint Health and Education Sub-Committee, which deals with matters pertaining to the school health service and health education in general; from a central Health General Purposes Sub-Committee which deals with matters of policy and finance, and with the ambulance service; and from the Joint Committee established to look after the affairs of the workshops for the blind which is financed jointly by the Cumberland and Westmorland County Councils and Carlisle Borough Council.

A Health and Medical Services Liaison Group meets twice a year to discuss the effects of policy decisions and actions by one branch of the Health Service on the others. The group is mostly professional, with representation from this authority, the Carlisle

authority, the Special Area Committee of the Regional Hospital Board, the Cumberland and Carlisle Executive Councils and the Cumberland and Carlisle Local Medical Committees. The aim of the group is to discuss matters of common interest at a very early stage but I am afraid that there is a danger of some items being discussed rather late in their development and sometimes of broad and important changes in policy not receiving due place. I do believe, however, that it is a very useful channel for closer liaison.

Liaison with the other branches of the health services is, of course, furthered in many other ways. Periodic bulletins are published to keep general practitioners in touch with the work of the department and I, or my deputy, attend meetings of the West Cumberland Hospital Management Committee, Garlands Medical Advisory Committee, Local Maternity Liaison Committees and the Cumberland Local Medical Committee. I attend meetings of the Special Area Committee of the Regional Hospital Board. These contacts are invaluable in helping to overcome the separation of the services which present legislation imposes but which will, it is hoped, be removed by some such changes as are outlined in the Green Paper. For some time there have been thoughts here on the establishment of departments of social health in the main hospitals, and as long ago as 1965 the County Council agreed in principle with the concept. Unfortunately, the idea has not been so readily accepted elsewhere and no firm agreement has yet been reached with the hospital authorities as to how it can be implemented. However, now that support is coming from a series of important recent reports I am more hopeful of success.

The recruitment of medical officers to "mixed appointments" with the county and the smaller district councils has been getting progressively more difficult over the past few years. In 1968 two district councils were without medical officers of health, another had a temporary, month-by-month arrangement with a retired medical officer, a fourth was about to become vacant by retirement with very little hope of making another appointment, and the fifth had a medical officer of health whose aggregate of county and district employment was little more than half-time; this out of a total of only twelve district councils. To meet this worsening situation a scheme was prepared to introduce more flexibility into

the system of mixed appointments and to make more effective use of the medical manpower available. Briefly, the proposal is to have the three Area Medical Officers and their deputies provide all the medical officer of health services to the county district councils within their administrative areas without any set allocation of time to individual councils, but with the allocation of salary on a population basis. This plan found favour with nine of the twelve county district councils and the authority, therefore, decided to make a scheme under Section 111 of the Local Government Act, 1933, notwithstanding the opposition of three of the councils involved. It was felt that the needs and wishes of the majority must prevail. I am hopeful that all will see the benefits which the proposals hold and that general agreement will yet be reached.

Area	Area Medical Officer	Districts covered	Total Acreage	Total population	Births in 1968	Child Health		Training Centres		Part III Accommodations		Sup. Ind. Places
						Centres	Attendances	Centres	Places	Homes	Places	
Northern	Dr. C. A. Bentley, 13 Portland Square, Carlisle.	Alston R.D.										
		Border R.D.										
		Penrith R.D.	612,000	77,520	1,132	15	9,249	1	45	8	210	150
		Penrith U.D.										
		Wigton R.D.										
Western	Dr. J. L. Hunter, Stoneleigh, Park End Road, Workington.	Cockermouth R.D.										
		Cockermouth U.D.										
		Keswick U.D.	173,000	74,120	1,170	8	8,368	1	50	3	94	112
		Maryport U.D. Workington M.B.										
Southern	Dr. S. Smith, Flatt Walks, Whitehaven.	Ennerdale R.D.										
		Millom R.D. Whitehaven M.B.	182,000	74,060	1,098	9	13,709	1	75	4	128	24

GENERAL STATISTICS AND SOCIAL CONDITIONS OF THE AREA

The Registrar General's mid-year estimate of population for the administrative county for 1968 shows an increase of 600 persons over the mid-year estimate for 1967. This does not, however, represent a real increase of these proportions over a twelve month period. Rather does it reflect a periodic bringing up to date of the figure, since this year the Registrar General has based his estimate on the final results of the Census enumeration of 23rd April, 1961 corrected for area of usual residence and adjusted by available data on the subsequent movement of population, including the 1966 Sample Census. None-the-less it suggests that the previously estimated rate of outward migration was a little on the high side.

The following table shows the estimated movement of population by district over the past year:—

District	Registrar General's Mid-Year Estimate		Population		Natural		Net Migration	
	1967	1968	Inc.	Dec.	Inc.	Dec.	Inward	Outward
Cockermouth U.D.	6,240	6,370	130		26		104	
Keswick U.D.	4,350	4,510	160			19	179	
Maryport U.D.	12,150	12,110		40	22			62
Penrith U.D.	10,880	11,200	320		2		318	
Whitehaven M.B.	27,050	26,960		90	152			242
Workington M.B.	29,900	29,990	90		100			10
Alston R.D.	2,060	2,060				2	2	
Border R.D.	30,890	30,920	30		3		27	
Cockermouth R.D.	21,160	21,140		20	44			64
Ennerdale R.D.	32,030	32,050	20		170			150
Millom R.D.	15,060	15,050		10	16			26
Penrith R.D.	11,480	11,420		60	55			115
Wigton R.D.	21,850	21,920	70		42		28	
TOTALS	225,100	225,700	820	220	632	21	658	669

It will be seen from this table that the main population increases are in the central and eastern urban districts where, in Penrith Urban District alone, an increase of 320 persons was probably due to the influx of labour for the M.6. labour force, which, when at its peak in July 1967 was approximately 870, falling to approximately 670 in June 1968.

There is still evidence of the outward migration from West Cumberland in the above figures where the net number of persons who have left the area is 422. The social and economic conditions in the southern area have not been helped by the closure of the Millom Ironworks and the supporting Ullcoats haematite iron ore mine at Egremont.

During the year I have collaborated with the Statistical Research Unit of the Medical Research Council in enquiries into suggested lung cancer hazard to haematite miners in the Ennerdale Rural District and Whitehaven Municipal Borough. There has been an extensive examination of death returns going back 20 years in the Whitehaven and Ennerdale districts. Analysis of the data extracted is still proceeding and I expect a conclusion to be forthcoming soon.

Vital Statistics

Births

The county birth rate of 15.1 births per 1,000 total population is the lowest ever recorded, the number of births having fallen from 3,601 in 1967 to 3,400.

The graph on page 36 shows the comparison of the birth rates for the administrative county and England and Wales. Although both rates are falling, influenced to some degree no doubt by more effective family planning, the more pronounced drop in the rates for the administrative county must also be affected by the outward migration of young persons in the child bearing age groups.

The total number of illegitimate births was 207, which represents 6.0% of total births. This shows a decrease in the proportion for 1967, which was 6.6%.

There was an encouraging drop in the number of stillbirths—44 compared with the high figure of 70 for 1967, giving the lowest stillbirth rate ever for the county—12.4 stillbirths per 1,000 live and stillbirths (provisional figure for England and Wales 14.4). This was also reflected in the lowest ever perinatal mortality rate of 23.2 stillbirths and first week deaths per 1,000 total births.

The following table shows the stillbirth and perinatal mortality rates over the past 10 years.

Stillbirths					Perinatal Deaths		
Admin. County				Eng. & Wales	Admin. County		Eng. & Wales
	No.	Rate	Rate	No.	Rate	Rate	
1959	...	83	20.9	20.8	137	34.5	34.1
1960	...	111	27.4	19.8	171	42.2	32.8
1961	...	76	19.1	19.0	129	32.4	32.0
1962	...	78	18.7	18.1	149	35.8	30.8
1963	...	76	18.8	17.2	136	33.7	29.3
1964	...	77	18.2	16.3	124	29.4	28.3
1965	...	80	20.0	15.8	117	29.3	26.9
1966	...	60	16.1	15.4	100	26.8	26.3
1967	...	70	19.1	14.8	108	29.4	25.4
1968	...	44	12.8	*14.4	80	23.2	*24.7
*(Prov.)							

*(Prov.)

The East and West Cumberland Maternity Liaison Committees continue to study all perinatal deaths, of which there were 80 during the year.

Maternal Mortality

There were no deaths associated with pregnancy in the administrative county this year.

Due to the small numbers involved the mortality rate per 1,000 total births has a tendency to fluctuate year by year, but the following table will give some indication of the progress made in maternal care.

		No. of Deaths	Admin. County Rate	Eng. & Wales Rate
1939-43	...	55	15.9	13.7
1944-48	...	30	7.7	7.4
1949-53	...	21	5.4	4.1
1954-58	...	17	3.6	2.6
1959-63	...	3	0.7	1.7
1964-68	...	5	1.3	1.2 Est.

Death Rate

There was a rise in the number of deaths—2,789, giving a rate of 12.4 deaths per 1,000 total population (England and Wales 11.9 (provisional)).

This year the Registrar General has extended the cause of death list and deaths are classified under the 65 headings based on the International Abbreviated List (B. List) from the manual of the Eighth Revision of the International Classification. This will improve comparability with the existing Abridged List of causes of death.

The main differences in comparison with the old list is to show better differentiation of "other defined and ill defined diseases", which classification has almost disappeared as a main cause. Strict comparisons with equivalent categories of causes although approximately similar cannot be assumed.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County—967,054 acres.

Rateable Value (April 1st, 1968)—£7,594,698.

Estimated Product of 1d. Rate (1968-69)—£30,321.

Population (Census, 1951)—217,540.

Population (Census, 1961)—223,202.

Population (1968 Mid-Year Estimate)—225,700.

Live Births — Number	...	...	...	...	...	3,406
Rate per 1,000 population	...	...	...	...	...	15.3
Illegitimate Live Births per cent of total births	...	...	...	...	...	6.6
Still Births — Number	...	...	...	...	...	4
Rate per 1,000 total live and still births	...	...	...	...	...	12.2
Total Live and Stillbirths	...	...	...	...	...	3,440
Infant Deaths (Deaths under 1 year)	...	...	...	...	...	6
Infant Mortality Rates—						
Total Infant Deaths per 1,000 total live births	...	...	...	...	...	19.3
Legitimate Infant Deaths per 1,000 total legitimate births	...	...	...	...	...	18.5
Illegitimate Infant Deaths per 1,000 total illegitimate births	...	...	...	...	...	29.3
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	...	...	...	...	...	13.3
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births)	...	...	...	...	...	10.0
Perinatal mortality rate (Still births and Deaths under 1 week combined per 1,000 total live and still births)	...	...	...	...	...	23.3
Maternal Mortality (including abortion) — Number of deaths	...	...	...	...	...	NN
Rate per 1,000 total Live and Still births	...	...	...	...	...	NN

A more detailed analysis of the above figures is given overleaf

	Male	Female	Total	Urban Districts	Rural Districts	Admin. County	Eng. & Wales (Prov.)
LIVE BIRTHS—							
Legitimate	... 1,635	1,564	3,199				
Illegitimate	... 99	102	201				
	1,734	1,666	3,400				
Birth rate per 1,000 population	...			15.8	14.6	15.1	16.9
STILL BIRTHS—							
Legitimate	... 25	13	38				
Illegitimate	... 3	3	6				
	28	16	44				
Still birth rate per 1,000 total births				14.4	11.6	12.8	14.4
DEATHS—							
All causes	... 1,417	1,372	2,789				
Death rate per 1,000 population	...			12.7	12.1	12.4	11.9
INFANT DEATHS—							
All infants under 1 year of age—							
Legitimate	... 29	31	60				
Illegitimate	... 4	2	6				
	33	33	66				
Total infant deaths per 1,000 total live births	...	...	...	16.7	21.4	19.4	18.2

BIRTHS, DEATHS, INFANT MORTALITY

				BIRTHS					
District				Legitimate	Illegitimate	Total	Births per 1,000 population (crude)	Comparability factor	Stillbirths
URBAN DISTRICTS—									
Cockermouth	...	...		105	1	106	16.6	1.00	—
Keswick	...	...		46	9	55	12.1	1.15	1 17
Maryport	...	...		161	13	174	14.4	0.96	6 33
Penrith	...	...		150	18	168	15.0	1.00	4 23
Whitehaven	...	...		452	12	464	17.2	0.93	4 9
Workington	...	...		434	37	471	15.7	1.00	6 12
Aggregate	...	...		1,348	90	1,438	15.8	0.98	21 14
RURAL DISTRICTS—									
Alston	...	...		27	2	29	14.1	1.25	—
Border	...	...		395	13	408	13.2	1.12	5 12
Cockermouth	...	...		271	21	292	13.8	1.02	2 6
Ennerdale	...	...		481	38	519	16.2	0.99	10 18
Millom	...	...		178	9	187	12.4	1.08	1 9
Penrith	...	...		172	13	185	11.4	1.07	2 10
Wigton	...	...		327	15	342	15.6	1.05	3 1
Aggregate	...	...		1,851	111	1,962	14.6	1.05	23 11
Administrative County	...	...		3,199	201	3,400	15.1	1.02	44 12

AND POPULATION IN THE YEAR 1968

DEATHS			INFANT MORTALITY										
Total Deaths	Deaths per 1,000 population (crude)	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	Estimated Mid-year population
80	12.6	1.09	1	1	—	1	1	9.4	9.4	9.4	1	9.4	6,370
74	16.4	0.81	—	—	—	—	—	—	—	—	1	17.8	4,510
152	12.6	1.19	4	4	—	1	1	23.0	5.7	5.7	7	38.9	12,110
166	14.8	0.89	2	1	1	2	—	11.9	11.9	—	4	23.2	11,200
312	11.6	1.16	9	9	—	7	5	19.4	15.1	10.8	9	19.2	26,960
371	12.4	1.15	8	6	2	7	5	17.0	14.9	10.6	11	23.1	29,990
1,155	12.7	1.10	24	21	3	18	12	16.7	12.5	8.4	33	22.8	91,140
31	15.0	0.85	—	—	—	—	—	—	—	—	—	—	2,060
405	13.1	0.87	4	4	—	2	2	9.8	4.9	4.9	7	16.9	30,920
248	11.7	1.10	7	6	1	6	6	24.0	20.6	20.6	8	27.2	21,140
349	10.9	1.22	20	18	2	12	9	38.5	23.1	17.3	19	35.9	32,050
171	11.4	1.27	3	3	—	3	3	16.0	16.0	—	4	21.3	15,050
130	11.4	1.04	3	3	—	1	—	16.2	5.4	—	2	10.7	11,420
300	13.7	0.93	5	5	—	5	4	14.6	14.6	11.7	7	20.3	21,920
1,634	12.1	1.04	42	39	3	29	24	21.4	14.8	12.2	47	23.7	134,560
1,789	12.4	1.06	66	60	6	47	36	19.4	13.8	10.6	80	23.2	225,700

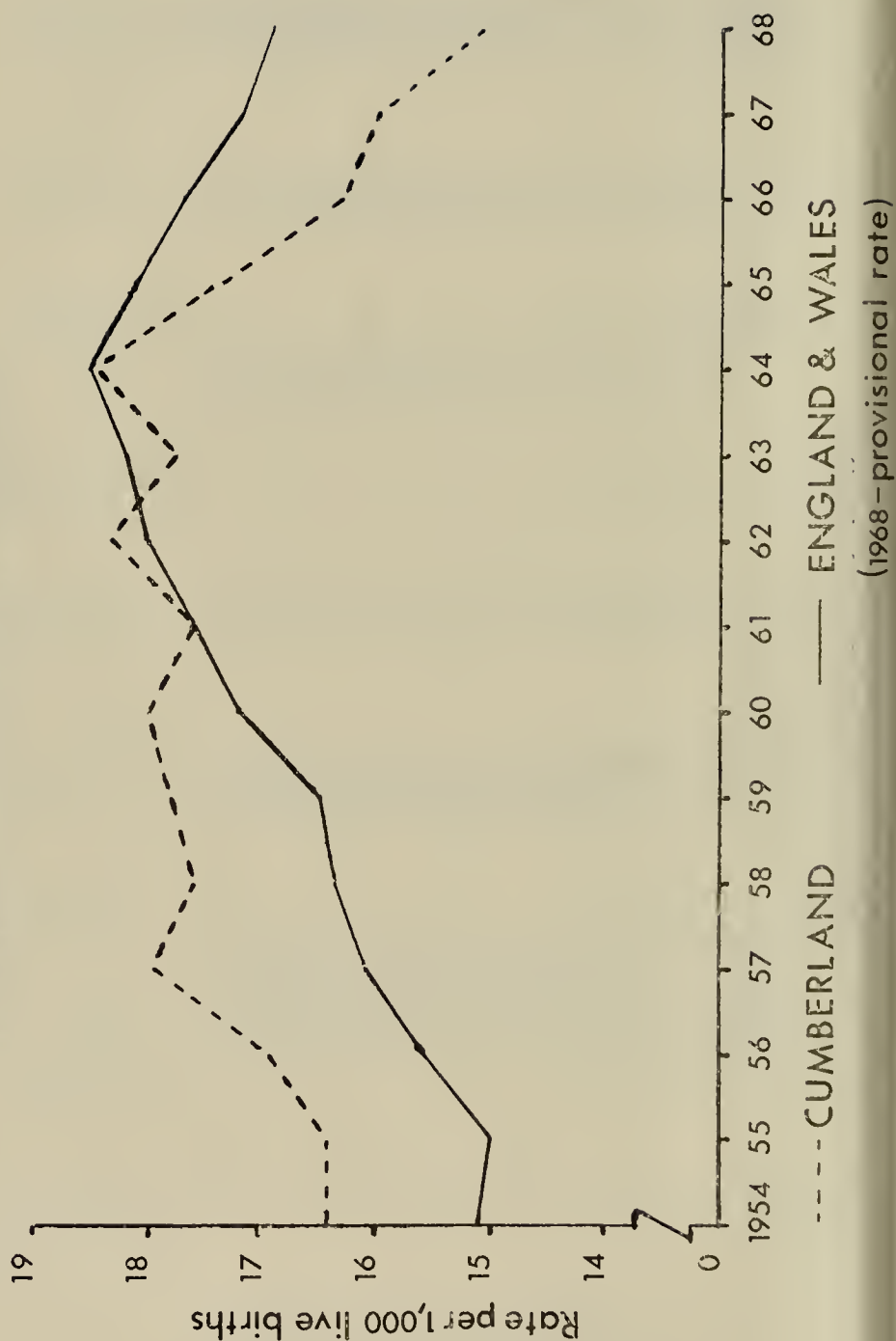
MORTALITY TRENDS IN CUMBERLAND

Year	Under 1	1—	5—	15—	25—	45—	65—	75+	Total
1928	237	104	83	105	253	585	613	617	2597
	9.1 %	4.0 %	3.2 %	4.0 %	9.8 %	22.5 %	23.6 %	23.8 %	Rate 12.3
1938	184	62	52	79	214	638	680	729	2638
									Rate 13.5
1958	108	18	9	24	113	607	677	1087	2643
									Rate 12.1
1959	82	8	16	27	81	575	712	1110	2611
									Rate 11.9
1960	91	13	19	21	105	554	677	1149	2629
									Rate 12.0
1961	88	7	19	19	86	570	747	1189	2725
									Rate 12.3
1962	108	15	13	15	114	574	759	1125	2723
									Rate 12.1
1963	87	8	11	33	97	648	721	1208	2813
									Rate 12.5
1964	76	19	14	24	88	626	705	1118	2670
	2.8 %	0.7 %	0.5 %	0.9 %	3.3 %	23.5 %	26.4 %	41.9 %	Rate 11.8
1965	66	11	13	29	89	618	750	1130	2706
	2.4 %	0.4 %	0.5 %	1.1 %	3.3 %	22.8 %	27.7 %	41.8 %	Rate 12.0
1966	77	6	13	25	96	588	732	1224	2761
	2.8 %	0.2 %	0.5 %	0.9 %	3.5 %	21.3 %	26.5 %	44.3 %	Rate 12.3
1967	61	7	11	29	84	593	696	1071	2552
	2.4 %	0.3 %	0.4 %	1.1 %	3.3 %	23.2 %	27.3 %	42.0 %	Rate 11.3
1968	66	9	16	28	100	632	789	1149	2789
	2.4 %	0.3 %	0.6 %	1.0 %	3.6 %	22.6 %	28.3 %	41.2 %	Rate 12.4

BIRTHS AND DEATHS STATISTICS

Year	Estimated mid-year population	Births:		Deaths:		Excess of Births over Deaths
		Number	Rate	Number	Rate	
1918	...	4,769	21.5	3,490	17.6	1,279
1928	...	3,782	17.9	2,597	12.3	1,185
1938	...	3,092	15.9	2,638	13.5	454
1958	...	3,834	17.6	2,643	12.1	1,191
1959	...	3,888	17.8	2,611	11.9	1,277
1960	...	3,940	18.0	2,629	12.0	1,311
1961	...	3,900	17.6	2,725	12.3	1,175
1962	...	4,085	18.3	2,723	12.2	1,362
1963	...	3,964	17.7	2,813	12.5	1,151
1964	...	4,147	18.4	2,670	11.8	1,477
1965	...	3,916	17.4	2,706	12.0	1,210
1966	...	3,670	16.3	2,761	12.3	909
1967	...	3,601	16.0	2,552	11.3	1,049
1968	...	3,400	15.1	2,789	12.4	611

LIVE BIRTH RATE 1954 TO 1968 CUMBERLAND and ENGLAND and WALES



CAUSES OF DEATH IN ADMINISTRATIVE AREAS

CAUSES OF DEATH		Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.	Whitehaven M.B.	Workington M.B.	Aggregate of U.D.'s	Alston R.D.	Border R.D.	Cockermouth h.D.	Emberdale R.D.	Millem R.D.	Penrith R.D.	Wigton R.D.	Aggregate R.D.'s
ALL CAUSES		2789	80	74	152	166	312	371	1155	31	405	248	349	171	130	300	1634
B4	ENTERITIS AND OTHER DIARRHOEAL DISEASES	4	-	-	1	-	-	-	1	-	-	-	2	-	1	-	3
B5	TUBERCULOSIS OF RESPIRATORY SYSTEM	4	-	-	-	-	1	2	3	-	-	-	1	-	-	-	1
B18	OTHER INFECTIVE AND PARASITIC DISEASES	7	-	-	1	-	1	-	2	-	2	-	1	1	1	-	5
B19(1)	MALIGNANT NEOPLASM - STOMACH	75	1	2	2	2	8	13	28	1	9	4	10	9	5	9	47
B19(2)	MALIGNANT NEOPLASM - LUNG, BRONCHUS	87	3	2	1	4	13	15	38	-	11	7	15	8	2	6	49
B19(3)	MALIGNANT NEOPLASM - BREAST	38	3	-	2	2	3	5	15	-	8	3	6	2	-	4	23
B19(4)	MALIGNANT NEOPLASM - UTERUS	13	1	1	1	-	1	2	6	1	1	-	-	-	-	5	7
B19(5)	LEUKAEMIA	9	-	-	-	-	2	-	2	-	-	2	1	3	1	-	7
B19(6)	OTHER MALIGNANT NEOPLASMS ETC.	270	11	8	15	19	18	36	107	2	38	27	36	14	21	25	163
B20	BENIGN AND UNSPECIFIED NEOPLASMS	11	-	-	-	-	1	2	3	-	2	-	4	-	1	1	8
B21	DIABETES MELLITUS	32	2	1	3	3	5	4	18	-	1	1	6	-	1	5	14
B22	AVITAMINOSES, ETC.	2	-	-	-	-	-	1	1	-	-	-	-	-	-	-	1
B46(1)	OTHER ENDOCRINE ETC. DISEASES	12	-	1	2	-	1	1	5	-	-	3	-	-	1	3	7
B23	ANAEMIAS	6	1	-	-	1	-	1	3	-	-	1	-	-	-	2	3
B46(3)	MENTAL DISORDERS	7	-	-	-	-	1	1	2	-	-	1	1	2	-	1	5
B24	MENINGITIS	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	1
B46(4)	OTHER DISEASES OF NERVOUS SYSTEM, ETC.	24	-	-	3	-	7	2	12	-	2	3	2	1	1	3	12
B26	CHRONIC RHEUMATIC HEART DISEASE	28	1	-	-	3	3	2	9	1	4	6	3	3	2	-	19
B27	HYPERTENSIVE DISEASE	61	2	3	4	3	3	6	21	-	15	9	4	-	1	11	40
B28	ISCHAEMIC HEART DISEASE	762	28	21	47	53	70	90	309	9	113	71	90	51	34	85	453
B29	OTHER FORMS OF HEART DISEASE	118	-	5	2	7	13	12	39	1	25	9	15	3	8	18	79
B30	CEREBROVASCULAR DISEASE	453	9	14	26	31	48	61	189	6	74	42	36	26	24	56	264
B46(5)	OTHER DISEASES OF CIRCULATORY SYSTEM	125	3	1	7	5	12	23	51	1	13	11	22	12	4	11	74
B31	INFLUENZA	16	2	1	1	1	2	2	9	-	1	2	2	-	1	1	7
B32	PNEUMONIA	90	3	1	7	4	15	9	39	4	17	5	10	4	6	5	51
B33(1)	BRONCHITIS AND EMPHYSEMA	132	2	5	6	7	17	29	66	1	16	11	18	9	3	8	66
B33(2)	ASTHMA	7	-	-	-	-	4	-	4	-	-	-	2	-	-	1	3
B46(6)	OTHER DISEASES OF RESPIRATORY SYSTEM	30	-	1	3	1	3	4	12	3	2	3	7	1	1	1	18
B34	PEPTIC ULCER	26	-	1	1	3	3	4	12	-	4	2	5	1	1	1	14
B35	APPENDICITIS	3	-	-	1	-	1	1	3	-	-	-	-	-	-	-	-
B36	INTESTINAL OBSTRUCTION AND HERNIA	10	1	1	-	1	2	2	7	-	-	-	1	1	-	1	5
B37	CIRRHOSIS OF LIVER	9	-	-	-	1	-	3	4	-	1	2	1	-	-	-	-
B46(7)	OTHER DISEASES OF DIGESTIVE SYSTEM	26	-	1	2	1	1	3	8	-	6	1	4	2	-	5	18
B38	NEPHRITIS AND NEPHROSIS	10	-	-	1	-	1	3	5	-	-	1	2	2	-	-	5
B39	HYPERPLASIA OF PROSTATE	9	2	-	-	2	1	1	6	-	3	4	1	2	1	2	13
B46(8)	OTHER DISEASES, GENITO-URINARY SYSTEM	26	-	2	1	3	5	2	13	-	1	-	-	-	-	1	2
B46(9)	DISEASES OF SKIN, SUBCUTANEOUS TISSUE	2	-	-	-	-	-	-	-	-	1	-	-	1	1	5	12
B46(10)	DISEASES OF MUSCULO-SKELETAL SYSTEM	15	-	-	-	1	2	-	3	-	2	-	3	3	1	3	19
B42	CONGENITAL ABNORMALITIES	28	-	-	2	2	3	2	6	-	1	3	3	3	-	2	12
B43	BIRTH INJURY, DIFFICULT LABOUR, ETC.	18	1	-	-	-	3	2	6	-	1	3	3	-	-	2	5
B44	OTHER CAUSES OF PERINATAL MORTALITY	7	-	-	-	-	-	2	2	-	-	1	1	-	-	4	10
B45	SYMPTOMS AND ILL-DEFINED CONDITIONS	30	-	-	-	2	13	5	20	-	-	1	4	2	4	3	27
BE47	MOTOR VEHICLE ACCIDENTS	51	2	1	6	2	8	5	24	-	9	2	7	3	3	7	43
BE48	ALL OTHER ACCIDENTS	71	1	-	3	2	14	8	28	1	15	3	11	3	3	2	8
BE49	SUICIDE AND SELF INFLICTED INJURIES	14	1	1	1	-	-	3	6	-	3	2	1	-	-	-	5
BE50	ALL OTHER EXTERNAL CAUSES	10	-	-	-	-	3	2	5	-	3	-	2	-	-	-	-

Year	Stillbirths per 1,000 total births			Perinatal deaths per 1,000 births		
	Early Stillbirths	Neo-Natal Deaths	Perinatal Deaths	Cumberland	England and Wales	Cumberland and Wales
1956	111	64	175	29.3	22.9	46.2
1957	102	64	166	25.5	22.5	41.5
1958	80	69	149	20.4	21.5	38.1
1959	83	54	137	20.9	20.8	34.5
1960	111	60	171	27.4	19.8	42.2
1961	76	53	129	19.1	19.0	32.4
1962	78	71	149	18.7	18.1	35.8
1963	76	60	136	18.8	17.2	33.7
1964	77	47	124	18.2	16.3	29.4
1965	80	37	117	20.0	15.8	29.3
1966	60	40	100	16.1	15.4	26.8
1967	70	38	108	19.1	14.8	29.4
1968	44	36	80	12.8	* 14.4	23.2

* Provisional

CUMBERLAND COUNTY PERINATAL DEATHS (locally compiled figures)

Analysis of Causes of Perinatal Deaths during 1968

Cause of Death	Stillbirths		Deaths during	
	Premature	Full-term	1st Week	Total
Toxaemia	5	1	1	7
Ante Partum Haemorrhage	7	2	4	13
Placental Insufficiency	3	1	—	4
Rh. with Antibodies	2	—	—	2
Maternal Diabetes	—	—	—	—
Prematurity	2	—	10	12
Congen. Malformations (including Congen. Heart)	7	2	9	18
Tentorial Tear	—	—	3	3
Asphyxia—				
Cord Round Neck	—	1	—	1
Intra Uterine	1	—	—	1
Pneumonia Inhalation	—	—	1	1
Atelectasis	1	—	3	4
Cerebral Haemorrhage	—	—	1	1
Placenta Praevia	1	—	—	1
Macerated Foetus	3	—	—	3
Post Maturity	—	1	—	1
No Known Cause	1	1	1	3
Pneumonia	—	—	1	1
Baby's Body Found on Shore	—	—	1	1
Spaldings Sign	—	1	—	1
Septicaemia	—	—	1	1
Chest Infection	—	—	1	1
TOTAL ...	33	10	37	80

Infant Mortality

Cause of Death	Age in weeks			Total
	Under 1	1 to 4	4 to 52	
Toxaemia	1	—	—	1
Prematurity	10	—	—	10
Congenital Malformations	9	2	—	11
Asphyxia	1	—	3	4
Atelectasis	3	—	—	3
Pneumonia and Bronchitis	2	3	6	11
Congenital Heart Disease	—	2	1	3
Cerebral Haemorrhage	1	—	—	1
Peritonitis	—	1	—	1
Gastro Enteritis	—	—	2	2
Ante Partum Haemorrhage	4	—	—	4
Tentorial Tear	3	—	—	3
Septicaemia	1	—	—	1
Meningitis	—	2	—	2
Lympho Sarcoma	—	—	1	1
Accidental Death	—	1	1	2
No Known Cause	1	—	—	1
Other Causes	1	1	3	5
	37	12	17	66

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales for 1958 to 1968, are as follows:—

Year	Rates per 1,000 total live births	
	Cumberland	England and Wales
1958 ...	28.2	22.5
1959 ...	21.1	22.2
1960 ...	23.1	21.8
1961 ...	22.6	21.4
1962 ...	26.4	21.7
1963 ...	22.0	21.1
1964 ...	18.3	19.9
1965 ...	16.9	19.0
1966 ...	21.6	19.0
1967 ...	16.9	18.3
1968 ...	19.4	18.2

NURSING SERVICES

Sections 23, 24 and 25 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to secure, whether by making arrangements with the Board of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period of not less than the lying-in-period, is adequate for the needs of the area.

It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own home."

FURTHER DEVELOPMENT OF COMMUNITY HEALTH SERVICES

Undoubtedly the principal initiative in recent years of the County Council Health Committee has been the steady build-up of the family health care team towards a more integrated and unified community health service. In 1968 this build up has continued in a very secure way and, as in previous reports, I will rely very much on the testimony of the direct participants for a commentary on the year's progress. Several family doctors, as well as my area medical officers, area nursing officers and individual nurses, have kindly—and I may add very happily—written down their views for publication in this report.

First of all, however, I would like to make a brief comment on one or two aspects of the teams and their work in 1968 which I believe are highly significant. One of the features of the entire scheme has, from the beginning, been the flexibility with which general practitioners have been encouraged to develop the work of the nurses in the team. A most gratifying point here is the small amount of conflict which has arisen between doctors and nurses, for initiative in the development of working together has been well shared between them. In every case however a "modus vivendi" has been arrived at, and each has demonstrated much to the other. The variation in the use of nurses within a practice emerges from some of the comments below and I am sure that the avoidance of any rigid pattern of working from the start has been an advantage. At the same time stress must be laid upon the need for continuing and frequent discussion of progress between doctors, nurses and my area medical officers and area nursing officers.

Surgery nursing has increased steadily as is shown in the section of this report more specifically devoted to practical nursing (See page 71). It will be noted in some of the nurses own comments, that nursing in the surgery and in the home are complementary tasks and I feel this must be very much borne in mind when any question arises of general practitioners employing their own nurses for work in the surgery. While this may be useful in some instances I am convinced that in most cases the better

solution is for the Local Authority—employed nurses to undertake both surgery and domiciliary work. Indeed it could well happen that with separate nursing teams in surgery and at home, valuable and very scarce nursing expertise would be wasted by overlap and lack of integration. If the doctor works in both surgery and home, why not his nurse?

Another problem which has been grappled with, but remains as yet incompletely solved, is the 'boundary problem' where doctors based in one local authority area serve patients in another. I am glad to say that arrangements are well advanced for the reaching of Hadrian's Wall in 1969 by nurses from Roxburghshire, attached to doctors in Scotland, but who have patients in North Cumberland. Both counties concerned have readily accepted the good sense of this. Progress towards integration with the city of Carlisle has been less but discussions are still proceeding. This latter point is particularly acute where nurses employed by the County Council work in city surgeries to serve county patients. An arrangement is sought which would allow these nurses to undertake a small amount of service to city patients for the convenience of the doctors.

Training is another aspect of the nursing service which has been prominent during the year—notably the completion of the first day-release course for district nurses organised by the local authority as distinct from the Queen's Institute, which no longer undertakes training. A fuller account of this course is given under 'Home Nursing' and one of its most gratifying features was the very valuable teaching time given by general practitioners and consultants and given so enthusiastically. The course leads to the National Certificate in District Nursing and all nurses who took the first course were successful.

I go on now to quote from those directly involved in the day to day operation of the family health care teams in the community. First of all from Penrith where one of the earliest ventures in "attachment" of the health visitor and nurses to group practice took place some 9 years ago, Dr. Lewis writes on behalf of his partners in the largest practice in that town:—

"We, in our practice, have now had district nurses attached for some years, and this system has proved very satisfactory. Perhaps a note about the practice itself would not be amiss, because clearly it is only in this context that we can express our views.

Our practice of four partners working from central surgery premises is in a market town of about 10,000 people, with rural area extending about 10 or 12 miles in most directions, and with about an equal number of patients in town and country. We are fortunate in having a G.P. Maternity Unit in the town and also a G.P. manned cottage hospital. An important point is that we are 18 miles from the nearest district hospital.

From the nurses point of view, we imagine the chief advantage of the present system is that they have a sense of belonging to a health team, and there is a measure of continuity which otherwise could not be achieved. We have two full time nurses and one part time nurse working with us, and their help is always given cheerfully and unstintingly. The patients are always grateful and full of praise for the nurses' work done in the patients' homes. One of our nurses has two sessions in the surgery clinical room we have for her for immunisations and dressings under our supervision. These run concurrently with our morning surgeries on two mornings in the week, and like our own surgeries, patients are seen by appointment. Following these sessions we meet the nurses and the health visitor over coffee to discuss mutual problems and arrange the work for the next few days.

From our point of view the nursing attachment has proved to be a great help in reducing the work load. We are able, more confidently, to treat illness, even relatively serious illness, in the home, knowing that the nurses' help can be quickly summoned. This is particularly important in our area where patients are often reluctant to make the journey to Carlisle, and under these circumstances perhaps we treat more serious illness in the home than our colleagues in a city. In the days, too, of earlier hospital discharge, after confinements or surgical operations, or once diagnosis is achieved and treatment instituted, the nurses' help in the patient's home proves invaluable. Their visiting of the

derly, and often lonely patients, for such things as injections and dressings, often becomes a social occasion which is looked forward to by the patients.

We in general practice are as much concerned with future developments of medical care as any other branch of the profession. There is no doubt that the demands for medical attention increase annually and are likely to continue. Faced with falling numbers of general practitioners we believe whole-heartedly in the full use of ancillary help whether it be secretarial, paramedical, or nursing. Organised properly, this could free the doctor for more essential medical matters, giving him the time to deal with real illness and not be snowed under by the trivia and the social problems which at present tend to be thrust upon him with increasing frequency. We are sure this trend must develop, although it may meet with some patient opposition at first. We are convinced that it is in his best interests, for, when time is too pressing, the important issues tend to be missed.

So far as our own practice is concerned, we should like to see an extension of the nursing service, to begin to include regular visiting of the elderly and the chronic sick which we ourselves do at the present. We believe it makes more effective use of our time if we were to visit once every three months some of these patients, instead of perhaps the monthly visit at present, if the nurses were to visit in between. Under these circumstances, instead of the largely social visit and for the writing of prescriptions, a quarterly visit would enable us to have the time for a complete medical examination. In the meantime however if there were any material change in the patients' condition the nurse would quickly come aware of it, and be able to inform us. An extension of the time spent by the nurses in the surgery would help, we believe. Two groups of patients who could be seen on many occasions by the nurse and perfectly adequately dealt with, would be the obese patient, where the surgery attendance is largely for weighing and mortation, and the hypertensive patient, usually on a regular regime, where the surgery attendance is largely for the purpose of checking blood pressure. These two groups of patients and perhaps some others could be seen monthly by the nurse, and quarterly by the doctor, in the absence of any material change in

their condition. It also seems not unreasonable for nurses to be trained to take blood specimens as is common-place in other countries.

The benefit from these suggested developments would not merely accrue to the doctors, but to the nurses themselves, well trained, and with a wealth of practical experience, who must at times become frustrated by the more routine and mundane matters such as bed baths. We believe they would enjoy and welcome additional responsibility and a more contributory part in total patient management."

Having dealt broadly with inevitable and desirable trends in family medical practice, Dr. Lewis indicates the important role of the community nurse of the future. One of the nurses in this practice team, Mrs. Relph, gives her impressions.

Mrs. Relph writes:

"Three years ago I became 'attached' to a group practice of four G.Ps. This was 'change', but from the beginning I felt 'change for the better', any small disadvantages being outweighed by the advantages of attachment, namely:

- (a) Work much more interesting. I am being used in my professional capacity, as a member of a family health care team, rather than an isolated worker.
- (b) Closer co-operation between G.P. and nurse means better family care.
- (c) Ability to have daily contact with G.Ps. plus twice weekly case discussion.
- (d) Good team work of G.P. and nurse means more patients are nursed, and kept mobile in their own homes, rather than being admitted to hospital. There has been marked reduction in the number of patients confined to bed, due I think, to more supervisory visits.

- (e) Reduction of G.Ps. case load, as I can take over selected cases after a primary visit by G.P. who always responds readily to an appeal for advice and further visiting of patient.
- (f) Increased confidence of the patients in the nurse who works with their G.P.
- (g) Better patient care, as I am now given diagnosis, case history and treatment programme, before visiting each new patient.
- (h) Stimulation to keep up to date with treatment and medicines, by more study and reading.

As the case load increased, a second nurse was attached to the G.P. team and a twice weekly 'Nurses Surgery' commenced. This is held two mornings a week, 9—10.30 a.m. Here we immunise, do dressings and give injections, using an appointment system. The possibility of an evening surgery is now being discussed. Smooth running of the 'attachment' scheme means there must be adequate relief, for off-duty and holidays, plus 'extra help' if there is a greater call on the services of the nurse than she can cope with, and in Penrith we have a part-time relief nurse, (a member of the Return to Nursing Club) attached to the practice.

With the increased work and responsibility of the 'attached nurse' there is a growing need for auxiliary workers. Some of the work, bathing, and foot toilet visits could easily be delegated. With more people being nursed at home, there is a need for more home-helps, perhaps this would be an even better service if home-helps were also 'attached'."

From another area a rural practitioner reports:—

"It was only when I was asked to put my thoughts on paper on the subject of county council nursing and health visitor services that I realised how dramatic the developments in this field have been over the past three or four years. This is particularly so in the work of the health visitor. In a sense these developments have been a question of making a virtue of a necessity. Clearly the

limit of a doctor's ability to cope with demand for medical services had very nearly been reached, particularly as no further increase in output of doctors from medical schools could be expected until the 1970's. Therefore, there were only two solutions to the problem—firstly to restrict public demand by the service ceasing to be free at the time of consumption, or, secondly, by relieving doctors of that portion of their work which could properly be done by those with less prolonged training.

The first solution was not a practical possibility. The second was, therefore, the obvious one. At least it appears obvious now, but all credit should be given to Dr. Leiper for appreciating this and for so energetically translating it into practical reality.

Cumberland can take a great pride in being a pioneer in attaching health visitors and nurse/midwives to individual practices, thus creating a domiciliary health team.

Turning to the nurse first; it is clear that home confinements, already less than 10% of the total, are likely to diminish further. We find, therefore, that there is very little domiciliary midwifery, but with the increasing popularity of the forty-eight hours discharge from the maternity hospitals, the quantity of maternity nursing is beginning to increase. There also appears to be an increase in nursing required by geriatric patients and much of the nurse's time is occupied with this. She is also invaluable in dressing surgical wounds and removing sutures because patients are being discharged from hospitals in increasing numbers soon after operation. This means an increasing turnover in hospital beds and also an increasing burden on the domiciliary medical services. The giving of routine injections in the patient's home has long been part of the nurse's duty and more than ever now this is of the greatest help to the doctors.

The health visitor has become indispensable. It would be almost inconceivable to run a N.H.S. practice without her. She checks on infant welfare. She has almost completely removed the burden of immunisations from the shoulders of the doctor. Routine injections, dressing of wounds and burns, testing of urines and taking of blood pressures, are jobs which she has taken over in

the surgery. For her to do these medical procedures has been of immense help, but even more important is the fact that she has dealt with much of the social aspect of general practice which absorbs so much time. She deals with the social agencies and can direct help to the aged and disabled. She arranges for home helps; for old people to go into Part III accommodation, and she can very often mobilise the goodwill of neighbours and relatives to look after old people who are ailing. She can direct the attention of the doctor to medical problems of which he may be unaware. Whether she will eventually take over completely the work of the general practitioner is perhaps questionable but that she will long continue to have an important part to play in the provision of medical attention to the community is quite certain.

I have only two criticisms to make—firstly, that I think it would be desirable for the health visitor to do her work in a uniform; the green costume previously worn was admirable. We have had occasional difficulties with patients not recognising the health visitor. Secondly, it is necessary to criticise the ludicrous parsimony which has led to refusal to pay for installation of telephones in the homes of part-time County Council nurses. In my experience this has hindered the efficient working of the service from time to time."

The above account and views are in the setting of the following account of the year's progress by the area medical officer, Dr. C. A. Bentley, and the area nursing officer of the area concerned, Mrs. J. Roberts:—

"The phrase 'family health care team' is now becoming a familiar one, and the great advantage of such teams is their versatility, for each area differs in its staffing requirements, nowhere more so than in the Northern Area where one third of the population of the County inhabit about two thirds of its geographical area. Here there are small practices and there are large practices, and it has been possible to contribute nurses and health visitors to all these practices simply because of this versatility. All staff, of course, are now attached to practices and so the year has been one of consolidation and development resulting in closer liaison between doctors, nurses and health visitors. Increasingly the

individual skills of each particular member of the team are becoming more fully recognised by other members with the result that a fuller and more comprehensive care for the community is being developed. For example the nature and value of the work done by the health visitor is being more clearly understood and appreciated by the general practitioners, and social problems of all age groups are being increasingly passed on to them for attention. Similarly auxiliary nurses or bath attendants have been added to some of the family health care teams to carry out the routine weekly bed baths, thereby releasing the district nurses for surgery duties or for nursing those patients needing more intensive professional care. S.E.Ns. are also being added to the family health care teams in increasing numbers and they are proving to be valuable members of the team, particularly for general nursing relief, and for assisting the health visitors with many of their routine duties. In many practices new clinics and surgery sessions have been started and one patient's comment on the inclusion of a nurse in the general practitioner's surgery was somewhat enlightening for she said 'It makes us feel more cared for, for we can discuss problems with the nurse that we would be afraid would take up too much of the doctor's time'. In Penrith, Brampton, Aspatria, Silloth, Longtown, Wigton and Dalston, district nurses, midwives and health visitors are going into all the practices to help with ante-natal care, treatment or baby clinics.

One large step forward in preventive medicine has been the great boost given to cervical cytology by health care teams during the year. As a result of collaboration between the Executive Council, the Local Authority, general practitioners, health visitors and nurses, letters are being sent to all women in the 'at risk' age group in many practices, inviting them to attend clinics at specific times for cervical smears. The response to this has been most encouraging, reaching as much as a 90% attendance in at least one area, and thus bringing many women for cytology who had not previously taken this opportunity. A number of women in fact have stated that for a long time they had thought about going to the clinics but an actual appointment had proved the final incentive. One busy group practice of five doctors has offered to send out further personal letters to the few defaulters.

to this scheme within their practice in an effort to get at the hard core of those women considered to be the most seriously 'at risk'.

Another aspect of preventive medicine has been the carrying out of a pilot survey by way of health visitors visiting those people in the practice who have reached their 75th birthday during 1968, and it was found that many of these people needed help such as social welfare, medical or surgical aid, help with bathing, chiropody, physiotherapy or domestic help. Here again the team approach proved its worth and the help required was easily organised on a family health care basis. The survey has proved its value and it is now hoped to extend this to the other practices within the area."

The variation in pattern of functioning of the nurses mainly viz a viz home and surgery emerges in some of the other contributions from doctors.

Dr. Leverton from Millom writes:

"How did we ever manage without our attached nurses? As in all organisations, Parkinson's Law applies to the work of doctors and nurses in this town. Our work load expands as we are able to do more, uncovering the iceberg of untreated illness. Does it all need treating?

The landmarks of 1968 were the arrival of our electrocardiograph in February and our full time surgery nurse starting work in June. Throughout the year we have learnt to work together as a team and have developed the content of our work.

Between 21st February and the end of the year, 168 tracings were recorded by the electrocardiograph, usually in the hands of a health visitor, both in routine sessions in the surgery and in the patients' homes at all times of day and often at a few minutes notice.

The full-time surgery nurse is steadily increasing her work. She has taken over the work of obtaining pathological specimens and sending them to the laboratory, she carries out treatments which previously were given by doctors and I suspect the treat-

ments are often done much better than previously. She has relieved the domiciliary nurses of treatments given to ambulant patients, who now attend surgery by appointment instead of waiting at home until the nurse is able to call. She is casualty nurse, chaperon and medical stores supply clerk.

The domiciliary nurses have been freed to extend the scope of their work. They have more time to spend in the home, advising as well as treating, and looking for illness before it causes serious symptoms. They are being helped by a bath attendant who informs the nurse or health visitor if trained nursing or medical care seems necessary. The domiciliary nurses are also able to carry out more diagnostic work, for example, collecting pathological specimens and checking blood pressures in medical cases and are better able to assist in the supervision of acute illnesses in the home.

The nurses and health visitors have taken over the routine supervision of the elderly and the chronic sick. They can advise and educate the patients more fully than the doctor is able, and call the doctor's help when necessary to deal with medical problems. The health visitors' work for other patients continues in the same way.

These changes in distribution of the work of caring for our patients have enabled the doctors to spend more time treating the acute illnesses, and, I believe, spend more time for better results.

When a group of doctors and nurses work as a team in the way that I have attempted to describe, it is essential that they should meet frequently and easily to discuss their cases. The surgery nurse can easily call the doctor to see her patient, but the domiciliary nurse must also have an opportunity to discuss her cases. We try to arrange this informally by providing half an hour each morning when we can meet, with coffee, and discuss our cases. It might be that in some cases a more formal discussion group would be more productive, but we have no experience of this technique. It can be very wasteful of time for those not involved with the case under discussion at any moment of the meeting."

And from one of the larger towns in the county Dr. Chalmers comments:

"At the conclusion of the first twelve months which have seen a full co-operation between our practice and the nursing services (general nursing, maternity, health visiting and welfare) I am more than pleased with improvement in the services to patients concerned, saving of doctors' time in certain respects, and a new co-operative spirit which has developed as a result of the closer relationship.

The health visitor reports regularly during morning surgery at the time of preparation of visiting schedules. At this time, some discussion takes place over current cases and the introduction of new ones. As this usually coincides with a visit of the general nurse (or nurses) the practice interest can be maximal.

1. The new babies. The child's registration is checked; also the usual check on urine, progress, feeding problems and advice to mothers are gone into. Appointments are issued for immunisation. As the health visitor attends inoculation sessions attached to the ante-natal clinic, there is close liaison with the midwife and pupil at this time. She provides invaluable help in the taking of cervical smears and recording at this and other times. She also gives invaluable service in doing 'Sweep' tests for cases of diminished auditory acuity, and is always willing to see that repeat prescriptions, etc. are delivered during domestic visitations.

2. The elderly patients, whose needs have become very difficult to meet, can be given much better coverage with her help. As many problems are medico-social, these would probably otherwise be missed for lack of medical time. She will also see to the provision of appliances, walking aids, etc.

The general nurses report almost daily and have done fantastic work with a back-log of "regulars" and time consuming chronic lesions. Their chief role is, of course, help with the management of many acute medical conditions at home which may otherwise have occupied a hospital bed.

Routine investigations of blood and urine are efficiently seen to. Essential nursing of elderly, periodic injection treatments, (B.12, Gold, A.C.T.H. Anabolic Steroid, Parentrovite, Insulin, etc.) have produced a coverage previously impossible. Most important perhaps is the increase in interest which has ensued for both sides as a result of the closer contact and discussions. To be able to refer to 'our nurses' in talking to patients facilitates acceptance of situations and arrangements previously difficult and awkward.

Maternity service attachment centres on the ante-natal sessions. In the three classes of mother:—

- (a) Consultant case (primipara and complicated cases)
- (b) G.P. unit case
- (c) Domiciliary confinement

—all are seen jointly by doctor and midwife. I think the benefit to the patient is enormous, and previous time wasting overlaps are avoided. The mother has a new security in meeting these two people together, and has problems dealt with by the persons best fitted to cope with them.

For the midwife the early hospital discharge case is known in advance, thus bridging an unsatisfactory position which existed in the past; then she had to manage the tail-end of a job by someone else. Duplication of effort in ante-natal care is avoided in domiciliary cases and in all cases there is much saving of time in connection with weighing and measuring, taking of blood, urine checks, etc.

The male nurse's services are particularly appreciated in home management of difficult cases of rehabilitation after acute illness and in elderly and cardio-vascular cases.

There is obviously plenty of scope for extension of the use of the various services, especially in connection with the elderly and there is the possibility of help in follow-up during epidemic times, when full coverage by the doctor becomes impossible. Many of the visits for injections and so on, could so easily be done at

the consulting room, if, as I hope, we could arrange nurses' attendance during surgery hours, at least in the mornings, thus saving much time in actual journeying."

The area medical officer of the Southern Area, in which both the above doctors work, comments as follows on 1968 underlining the progressive integration of different levels of skills within nursing and the addition of other workers to the domiciliary team.

Dr. Smith writes :

"During the past year in the Southern Area the community health teams have been consolidating their progress. We now have been able to supply each nurse in each team with a relief nurse who stands in for her on her days off, holidays and in case of sickness. This means that the team is not overburdened when one of the members is absent.

In order that the family health care team can operate more smoothly and decisions be made quicker on the day-to-day running of the team, in two areas one of the team has been appointed group adviser. She is then able to delegate the work to the rest of the team and cope with local situations which arise from time to time.

In order that the skills of the higher qualified members of the nursing team are used to the full, we have tried to relieve them of duties which could be done by someone not so highly qualified. In the case of the health visitors, this has been done by relieving them of routine school medical work by appointing part-time school nurses. The health visitor, however, still supervises the health education in the school. Also, some of the routine district work of the health visitor has now been taken over by the district nurse, which includes some of the visiting of the elderly people. The district nurse has also been relieved in many cases by making use of nurses with an S.E.N. qualification and in one group they have also been relieved of routine bathing of patients by the appointment of a bath attendant.

In one group practice a part-time physiotherapist has been attached and this is found to have been very successful. The physiotherapist is able to supervise and help physically handicapped children and adults and is able to start treatment early in patients who have had such conditions as strokes. One other practice will also have a physiotherapist attached in the near future. Expansion of this type of work is, however, limited by the short supply of physiotherapists.

During the year we have attempted to attach, or perhaps *liaise* would be a better word, social welfare workers to the practices. At present in the Southern Area five of our social welfare officers have regular liaison with group practices.

In all, during the year the groups have become more consolidated and by further attachment we are now progressing to a much more compact health group".

Variation is again apparent in the Western Area, associated to some extent with geographical differences in practices. From one of the larger urban practices Miss Young writes:—

"During 1968 the work in the surgery has increased. Figures show that 30% more cases were treated in 1968 than in 1967.

Two interesting new developments have been evident.

1. An increased number of our patients know of the surgery nursing service available, and use their visits as an opportunity to disclose and discuss the personal, social and medical problems of their families which otherwise are not dealt with because the patients 'don't want to bother the doctors'. Without my experience of district training and nursing I would feel inadequate to advise, and unable to direct them to the appropriate sources of help. These include the loan equipment service, home help service, family planning clinics, Citizens Advice Bureau, W.V.S. for help with bed linen and clothing.

2. The surgery work and the district work are complementary. Many cases previously treated on district, and known to me eventually come to the surgery and it is possible to give follow-up treatment and advice there. Conversely many patients requiring maintenance doses of cortisone, cytamene, deca durabolin etc. are visited by me in their homes if they fail to keep the surgery appointment.

The overall responsibility of the district and surgery nursing services enables me to give family health care to a large number of families, and thereby provides a better service to the patient, and increased interest and satisfaction to me."

From Cockermouth and a more rural situation, but with a small local hospital Dr. Irvine gives his views:—

"This is a subjective review of the attachment of the domiciliary nursing and midwifery services available to myself in a single-handed rural practice.

The practice is of above average size for a rural list and is based on a central surgery in Cockermouth. It covers an area of radius 10 miles. About 60% of the patients live in Cockermouth the remaining 40% are rural. 12% are over 65. The county health department provide the services of a full time district nurse cum midwife, Nurse Clark, and a full time health visitor who is also the Lorton district nurse, Nurse Reynolds.

The attachment of the district nurse and health visitor is an indispensable part of my medical practice. Without their help, good nature and willingness I would question how efficiently I could continue in single-handed practice. Being attached to me by the Cumberland County Health Department removes the major financial burden of having to find and employ such highly trained staff and takes care of the problem of providing deputies during sickness and holidays. We meet daily before the morning surgery to integrate our work and deal with problems arising from the previous day.

The health visitor deals with the initial care and followup of new babies born in the practice and advises on infant welfare problems. She liaises with the local authority for home help, meals on wheels, and arrange for voluntary help for needy families. She works closely with the local schools and through the various channels of administration, health, education, housing, has played a vital part in initiating and dealing with the composite problems that occur in general practice. She does a twice monthly infant welfare clinic in the surgery where the prophylactic immunisation programme is carried out. It is difficult briefly to enumerate the various problems she is prepared and competent to deal with. One's only regret is that with so many primary administrative problems, the function of health education cannot be sufficiently dealt with—to do so could require two full time health visitors.

Turning to the district nurse, her most invaluable work is done in the care of the rather long term problem affecting particularly patients approaching their terminal illness, but systematic treatment and daily nursing care either alone or with relatives, of most medical problems is eminently feasible. Parenteral treatment, dressing of wounds of patients discharged early from hospital, burns, etc., are all dealt with by the nurse. Diagnostic procedures, blood and urine samples, taking swabs and despatching them to hospital are an invaluable part of her work. Domiciliary preparation of patients for diagnostic radiology saves outpatients time.

As regards cervical smeals, these I prefer to do myself—principally because I think this procedure should be associated with pelvic examination.

One is intrinsically grateful to these nurses for being available at other times—for I am sure that with their commonsense and kindly experience they help to stay the ever rising flood of requests made for attention to the most trivial of complaints.

My district nurse also works once weekly at Cockermonth Hospital and keeps up general practice diagnostic and treatment procedures.

As regards midwifery I feel that if the high obstetric risk cases are excluded a place exists for domiciliary confinement. The interminable wait in obstetric clinics, seeing a different doctor each time, finding someone to look after the children, difficulty of access to the District General Hospital and the rather arbitrary confinement to hospital for 10 days often leaves its mark on expectant mothers. The relaxed approach of a carefully selected woman for home confinement has only to be seen to make one feel that this service still has a place. In this district one regrets the absence of a general practitioner maternity unit and such a unit based on the Cottage Hospital would materially satisfy these critical objections that the mother-to-be often voices in the surgery.

Looking to the future, I see the scope of the nurses working arbitrarily increased both by medical advances and by the public demand—I do not feel that the present limitations of public and ambulance transport permit their services to be centralised, say in the surgery, and more so I do not feel that to take the patient out of their home environment necessarily improves the patients' care.

I cannot see within my own concepts of medical practice that the nursing services can be used as the first line for assessment of patients at home. It is an unfair responsibility to ask patients to accept. However, after initial assessment of the medical and social situation I feel that the nurses have a valuable role to play in alternating domiciliary visits with the family doctor. This does provide continuity of patient care and exposes the nurses to a wide range of patients in their attached practice. The mutual advantages are considerable.

I would react strongly to any attempt to centralise family doctors in hospital and in a similar way react to centralising nurses in clinics.

In conclusion, the doctor-nurse relationship in practice is unique. Improving this relationship lies in an all round improvement of general medical and nursing care as applied to practice. It is vital to continue to provide facilities to do this essentially human and vocational work".

Also from Cockermouth, a nurse writes:—

“In Cockermouth the general practitioners use the local hospitals for their out-patient sessions to a great degree as they have to use the x-ray apparatus and the electrocardiogram machine. I attend and help at these sessions every Thursday morning. This provides continuity between the general practitioners, the hospital, and local authority nurse. They cover a wide range of nursing treatments and examinations.

This experience is extremely valuable. It enables the nurse to keep up to date with the general practitioner methods of treatment, and to know more patients in the practice. It enables me, as a midwife, to see the final results of my midwifery patients at the post natal clinic”.

Rounding off the overall picture in the Western Area, Miss Crossfield, Western Area Nursing Officer writes:—

“Early in the year the one nurse who was working solely as a relief nurse left the area and she was replaced by nurses employed as reliefs on a practice basis. Two part-time nurses, one S.E.N. and one S.R.N., commenced work as domiciliary nurses which also helped the work of the teams to be better contained within their own membership.

“Most of the relief nurses have been drawn from the Return to Nursing Club and although all the full-time staff do not yet have a relief, these are being appointed as soon as they can be found. The membership of the Club continues to provide a reserve pool of nurses, although some of them want only full-time work and few are car drivers.

“In Workington, due to the decline of home confinements, the two midwives were re-designated as home nurse/midwives, each with a responsibility to certain of the doctor groups and a relief home nurse/midwife covers their off duty time.

“More of the staff are involved in various aspects of work in the surgeries, which includes nursing treatment sessions, weight control clinics, antenatal clinics, cervical cytology (5 sessions com

nenced in 1968) and home nurses are helping and relieving the health visitors at child welfare clinics. The variety and interchange of various nursing categories at these surgery sessions is indicative of the general pattern of working within the frame of the family health care team and of the members finding relief workers within that team for specific sessions.

"From visits to surgeries, I have found more of the teams are gathering at the one time and discussing the day's work together with the result that visits become interchangeable between the members, and the nurses are tending to take more of the repeat visits off the doctors' lists.

"Doctors working singly still pose a problem as some do not have sufficient work for a team of full-time nursing staff and the use of part-time staff is not entirely satisfactory, as it means that any evening work has to be done by nurses from another practice. In the main, these doctors are supported by sharing full-time staff and their appropriate reliefs.

"The post of Group Adviser for Maryport has been advertised more than once with no suitable applicants as yet. This idea of group adviser or team leader is one which could be expanded and there could possibly be openings for two more in this area in the near future."

Mention has been made above of the part which a small local hospital can play in completing the pattern of community health services in an area remote from a District General Hospital. The use of such a unit in the scheme of things is described as follows by Miss Knibbs, a Group Adviser in the Northern Area, writing of the use of Brampton Cottage Hospital, especially in relation to geriatric cases:—

Miss Knibbs writes:

"The Cottage Hospital of 6 geriatric beds plays a vital role in the community for providing continuity of patient care and deeply involves the family health care team.

"Discussions take place between G.P., Matron, H.V. and district nurse, to ensure minimum distress for patients being admitted or discharged from hospital. Ensuring adequate support from statutory or voluntary organisations for a relative left a home or for the patient on discharge.

The G.P. unit gives these old people medical care in familiar surroundings closely supported by their relatives and neighbours cared for by their own general practitioner and visited by members of the health care team. This close liaison makes for smooth admission and preparation for discharge with minimum distress to the patient".

I have also touched on the problems of local authority boundaries and it is from a Carlisle City based practice that Dr. Jolliffe writes as follows:—

"In this practice, we have now enjoyed full attachment for a full year by the Medical Officer of Health for Cumberland of two nurses. The patients of this practice are partly drawn from the Carlisle Health Authority and partly from the Cumberland Health Authority. As we have no nursing attachments from the Carlisle Health Authority, we have an opportunity of comparing practice with and without nursing attachments. Experience has brought us strongly to favour the former. We meet our nurses constantly and so our liaison with them is excellent, since we are dealing with a 'kent face' and not a disembodied voice on a telephone. Our nurses perform numerous ancillary services in our own surgery where they have their own room. Such services include immunisations, cervical smears, taking of pathological specimens, blood, etc. and all such other examinations which have been for ourselves most time consuming in the past. This experiment, if indeed it now is an experiment, has proved an unqualified success and we recommend it without any reservations."

From the same practice, one of the practice nurses, Mrs. Branthwaite comments:

"I have been attached to a group practice for just over one year and with it has come a greater satisfaction in my work. The doctors in the practice have given me a great deal of encourage-

ment and help, they are very willing at all times to discuss the progress and treatments of the patients I attend. This was often difficult in the past.

"The practice has a large number of City and County patients, but unfortunately on the district I can only visit those in the County. The type of work has altered a great deal, there is still, of course, the usual run of general nursing care, injections, dressings and baths out on the district, but now I also do visits to those just released from hospital and some return visits, again saving the doctors time.

In the surgery sessions, in which I help four times a week, the work has become varied and interesting. The babies are all sent to me for their prophylactic treatment, during these visits I often find the mothers want to discuss personal problems such as, family planning and weight reductions. I do a large number of cervical smears and the taking of blood, etc., for pathological reports, in fact, as many patients as possible are passed on to me in order that the doctors can spend more time with those in need of their attention.

"The practice has obtained an E.C.G. machine and currently am learning how to carry out these tests.

"From my experience, over the past year, of this system I can definitely say I feel it is a much better way to carry out the duties of a district nurse, the combination of close contacts with the doctors, surgery work and home visits, all add up to, as far as I can see, a better, a more efficient and happier service to the people who matter—the patients".

It will be recalled from some of the above contributions that progress is steadily being made towards each practice nurse in a team having a part-time relief nurse who "covers" her for time off duty, sickness, holiday etc. Such an arrangement is ideal in many ways and its realisation is made possible by the use of the Return to Nursing Club members. However, there are practical problems involved too, some of which are indicated by Mrs. Fisher a relief nurse in Workington, who sees her role in the team in the following terms:—

"I think the relief nurse in the family health team is essential to both doctor and nurse; also the patient. The relief nurse can be a benefit to both doctor and district nurse because continuity is necessary to operate a health team properly. In time a relief nurse knows the ways of the team but it is essential she meets the G.P. sometimes since on holidays and if the district nurse is ill, she has to work with him. The patients appear to like the idea of the same person relieving on 'Nurses day off'. I have not found any difficulties up to now, as the nurse I relieve for and myself work well together and agree on most things.

"The post of relief nurse fits in well for anyone with a family and commitments, and helps to keep a nurse who would otherwise be out of date with methods and treatments in touch with everything.

"I know it is impossible for everyone to be supplied with a telephone but if it becomes possible, I think it essential for a relief nurse to have one installed—if she is needed to relieve urgently and could take a turn of being on call especially during holidays or an influx of work.

"For myself, I find the work enjoyable but not fully satisfying. My home commitments are changing now and I find the hours and times are not really enough to get into the feel of things. By the time you are back on duty again, the work can change a lot and you lose the thread".

I think all of the above gives a very comprehensive picture of the present state of evolution of the family health teams in Cumberland. Many lessons have been, and may remain to be learned, but I feel satisfied that the experience described in these pages represents progress in the direction which is daily becoming more clearly established as right and sound.

I could have wished for more progress in the County towards better premises to house these developing community health services, but there has been singularly little interest in health centre development. So long as general practitioners feel, as most do in Cumberland, that premises provided or developed by the practice itself

is the better answer, I am principally concerned that such premises should, without fail, provide adequate accommodation for all of the teams. I believe it is becoming daily more clear to the general practitioner that this is so.

I proceed now to deal in a little detail with each of the main sections of the local authority nursing service viz health visiting, home nursing and midwifery. I hope, however, that what has been printed above in this account of the service as a whole will sufficiently stress the essential unity of the practice team and the importance of interweaving the various specialist nursing disciplines and levels of nursing training and expertise.

Home Nursing

We are all well aware that community needs are always changing, that patterns of work change; the tremendous advances in medical science have produced new drugs, new treatments, new ideas of rehabilitation, all of which affect the pattern of nursing care and the need for increased knowledge in techniques and the side effects of drugs and the challenge to rehabilitate the patient to his full mental and physical potential. The formation of family health care teams has brought with it many changes to the community, the general practitioners and to the nurses themselves, which have been described in this and previous reports.

This year has seen the increased introduction of relief and part-time home nurses to each team. Many of these nurses and some of our full time staff were not trained in community nursing and it was found necessary to set up District Nurse Training on a day release basis. I was delighted that nurses from Carlisle City, the Counties of Dumfries and Kirkcudbright joined the first course, which commenced in September, 1968. It is most satisfying to report that the 18 students attending were all successful in passing their examination and will be awarded the National Certificate in District Nursing.

The following account by Mrs. M. Dobson, one of the nurses on this first course, gives a very candid picture of her experience:—

“The course planned by the Local Authorities is on a Day Release basis and in September, 1968, I was one of some eighteen nurses selected to attend this course, the first of its kind to be held in Cumberland. It was therefore new ground for all concerned and its progress was watched with much interest. To complete a programme for twelve weeks, i.e. twelve full days in consecutive weeks was a difficult task, and the fact that the students were provided with all the details a few weeks before the course began, gives evidence of much advance thought and effort; the fruit of these labours was further demonstrated as our lectures continued with scarcely any deviation from the original plan. With few exceptions the members attending this particular course had been

trained for a good number of years, one or two of us stemming from the prepenicillin era. Time had erased from the memory the arduousness of attending and writing-up lectures, but this amnesia was soon to be cured as we plunged into a wide variety of subjects, ranging from a history of Public Health in all its departments, the usage of modern drugs, through to the 'haute couture' surgery of the present day.

"It was evident that all our lecturers had undertaken their task seriously and with interest; and they were all most agreeable in answering questions, within their given time limit. With no disrespect we felt that the G.P's. were more in accord with our needs than were the consultants. This is understandable as the G.P's. and D.N's. work in the same field, and this again shows the need for more liaison with, and understanding of our hospital colleagues. We began this in Cumberland some time ago, and its furtherance can only benefit everyone, not least our patients.

"We had not anticipated that one should find the course so, tiring, both mentally and physically. Most of us had a fair distance to travel, domestic arrangements to make, relief for our professional duties to provide and some work for the course to be done during the week. Despite the difficulties and because so many married nurses have returned to the profession, I cannot think of a better scheme than the Day Release system, but extended, as is now being done, in Cumberland. Some aspects of the timing of our course proved unfortunate. Beginning in September it was completed early in December, with the examination arranged for mid-January, 1969. This intervening period although less festive because of the Damoclean threat over us, was sufficiently long to allow one's brain to revert to their cosy inertia! Perhaps one or two days as a "refresher" just prior to the examination would have been of benefit.

"As treatments and techniques change so rapidly we should have welcomed an opportunity to have recourse to a library, although our tutors did make great efforts to

provide us with relevant literature. Another deficiency was an inability, because of the time limit to have adequate discussions and exchange of ideas amongst ourselves. We regretted the lack of opportunity to become better acquainted with one another and tended in the best British tradition to remain with our colleagues from our own area. It was a general wish that we could have had more practical work; as our lectures were held in a building within the grounds of the Cumberland Infirmary, perhaps, had once again time allowed, we could have attended an O.P.D. or a clinic, e.g. diabetic, cardiac, as hospital patients are so often handed over to the district nurse, especially the long term cases.

"It is fairly easy with hindsight to be critical and our Senior Officers aware of this invited our criticisms in the presence of Miss E. M. Johnston, from the Department of Health and Social Security, who attended on the last day. This opportunity was gladly seized and we were quite verbose! But in fairness, I must state, that we were mindful of all the work done in preparing the course, and the help and encouragement given us. Dr. Leiper, County Medical Officer, attended on several occasions and was always au fait with our progress. Miss Blockey, Chief Nursing Officer, was the guiding hand and Miss Hayes, deputy, was indefatigable in her enthusiasm and interest. Our own area nursing officers, supervised us in our practical work and were ready always to help us with our difficulties.

"It was, overall, a good course. As time passes and a set plan is evolved I am sure that the new district nurse will be as well equipped in her role, as was her predecessor, the so well known 'Queen's' nurse."

The appraisal of the course by these mature nurses was most constructive and helpful in the planning of other training schemes which will be started in Southern Area next year.

But all community nursing care does not need the specialised skills of a state registered nurse with district training. There has been through the year a gradual furthering of the help given by

the S.E.N's. and the bath attendants. Each of the three areas have two S.E.N's. and there are three auxiliary nurses at present in post. Although these numbers are small I feel they are vital members of our staff, and I hope to recruit many more.

There is not sufficient work for each family health care team to have a male nurse, but where there is a reasonable population the male nurse can and does make a valuable contribution to the community services.

A male nurse reports:—

“I work for all the Workington family doctors. I am not seconded to a particular practice, therefore I visit each practice at least once a week for discussion on the diagnosis, treatment, rehabilitation, and social aspects of the patients' environment. Liaison with the other members of the health team must be two-way communication with the general practitioner concerned.

“The area nursing officer keeps me fully briefed on patients discharged from the geriatric unit, West Cumberland Hospital, regarding treatment, rehabilitation, and the patients' social environment. This makes the rehabilitation of the patient at home, especially during the most important initial period following discharge, more efficient. Also, I am able to give the area nursing officer information on the patients in my care who are admitted to the West Cumberland Hospital

“Work in association with the welfare officers is necessary for comprehensive family care; particularly in matters of mental health, and the social aspects of the patient's environment. The social welfare officers and I, by working together, have managed to maintain a family at home in face of varied physical, mental and social problems.

“Whereas the official function of home helps is to give practical help with housework they, in fact, also assist in the social integration of the patient. This helps alleviate the patient's social isolation. The meals-on-wheels service besides supplying meals, offers a social contact which also helps alleviate social isolation.

“The Red Cross Service loan and equipment service is essential to the basic nursing care of the patient and every effort is made to supply the demand”.

We are all in agreement with a more unified nursing service. The local authority staff and the general practitioners are now working very closely together but there could and must be a closer link with the hospital. A nurse, Mrs. J. V. Clark, reports on her link:—

“In Cockermouth the general practitioners use the local hospital for their out-patient sessions to a greater degree in that they have the use of X-ray apparatus and electrocardiogram. These sessions are designed to fit in with the limited transport facilities that exist for pathological investigations and provide continuity between general practitioners and the hospital service. How then could the district nurse get her toe in? She knocked on the door and politely asked for admittance. The door opened widely and a pair of hands were never so warmly welcomed! Staffing problems can be very difficult at times in hospitals.

“This field is rich in experience and here is an impressive list to prove it:—

Vaginal examinations, cytology, post-natal checks, post-operative checks and treatment.

Accidents (a) fractures for X-ray or applying or removing plasters, dislocations and sprains. (b) Burns and scalds, cuts and bruises. (c) Stitching or removal of stitches.

Varicose veins treatment being either by injection, decision to operate or post-operative check; treatment of varicose ulcers.

Ears syringing, injections, antibiotic, antitetanus etc.

Minor operations e.g. removal of cysts, foreign bodies, tapping scrotal hydroceles.

Rectal examinations and treatment for haemorrhoids.

"This experience is extremely valuable. It enables the nurse to keep up to date with the general practitioners' methods of treatment, and to know more patients in the practice. It enables the midwife to see the final results of her midwifery cases".

In Cumberland, one hundred per cent of the home nurses are now "attached" i.e. a member of a practice team and an ever growing number of part-time and relief nurses are being employed. In 1967 there were 36 such staff; by the end of 1968 this number had increased to 61.

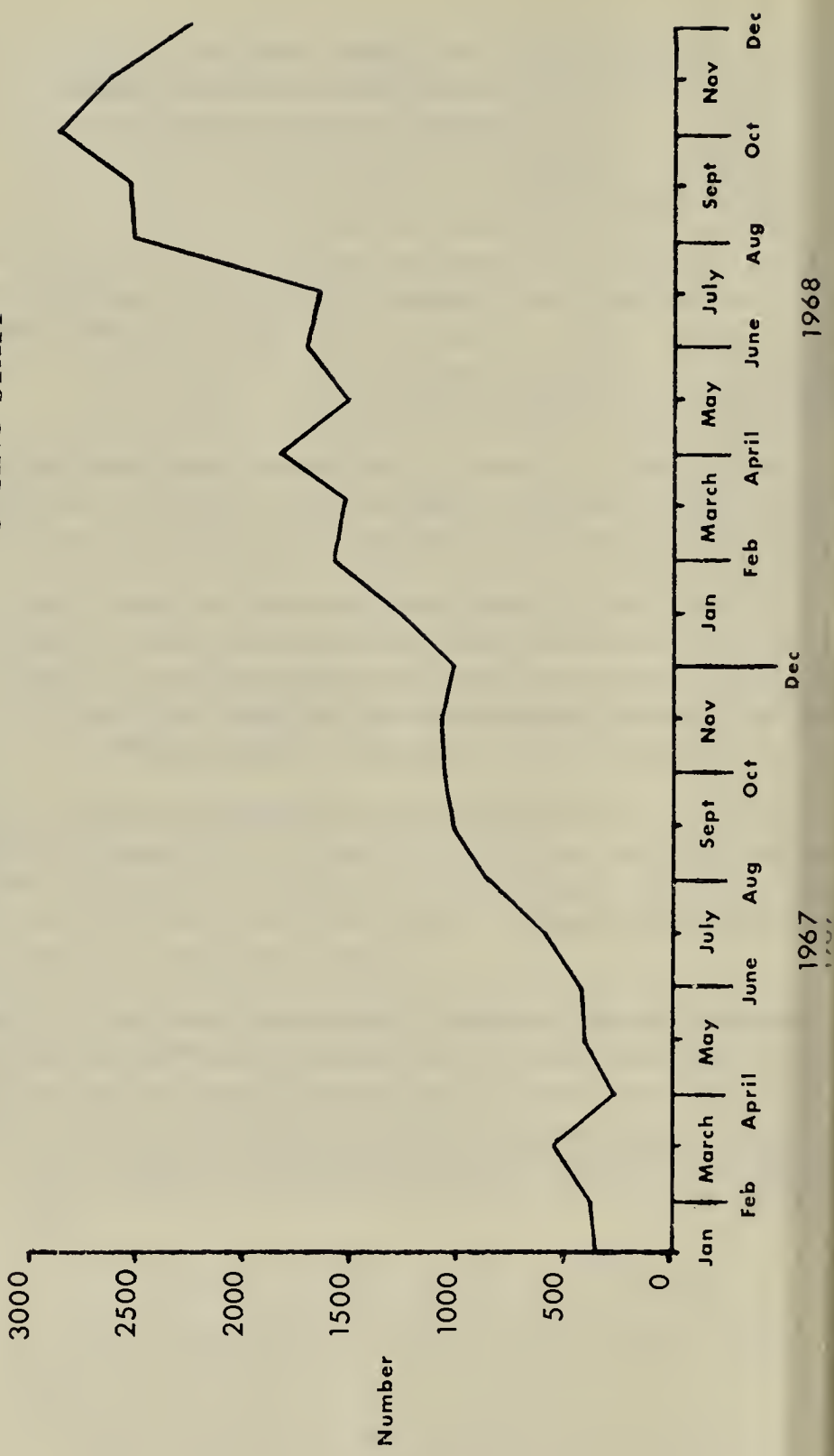
The number of patients nursed in their own homes shows only a slight increase over that for 1966. The total individual patients nursed was 7,891 (6,331 in 1967).

It seems clear that the 'home' nurse of the future is going to spend a great deal of time working in the surgery alongside the general practitioners, while the routine baths and injections will be given by other members of the family health care team, namely, the state enrolled nurse and the bath attendant.

The graph below shows the growth in surgery treatments given by local authority staff since 1967, and it will be seen from this that under 500 treatments were carried out in January, 1967, and at the end of 1968 the 2,500 a month mark had been passed.

This rapid development in surgery nursing I have already commented on and I would also in this connection draw attention to the section of this report on the work of the ambulance service. I comment on the need for the future development of a comprehensive transport service which would facilitate the carrying out of many more nursing procedures in the health centre or group practice centre.

SURGERY TREATMENTS GIVEN BY NURSING STAFF



Home Nursing

		Total number of persons nursed during the year	Aged under five at first visit	% of total cases nursed	Aged 65 or over at first visit	% of total cases nursed	Remaining cases	% of total cases nursed	% of total cases nursed	Surgery treatments	Total number Nursing Visits
1964	...	6167	448	7%	2966	48%	2468	41%	—	—	134,305
1965	...	6105	433	7%	3059	50%	2334	38%	—	—	150,656
1966	...	6159	276	4%	3479	57%	2120	34%	2517	2517	161,984
1967	...	6331	361	5%	3516	56%	2454	38%	8007	8007	172,415
1968	...	7891	414	5%	4153	53%	3324	42%	23,935	23,935	177,360

'Return to Nursing' Clubs continue to flourish. Each of the three areas in the county has monthly lectures on subjects of professional interest—bringing nurses up to date in the use of new drugs, new treatments and the development of community services. During the year a new advertisement was used to try and attract new recruits. There were 64 replies from interested nurses.

These Clubs provide a valuable source of recruitment for part-time and relief staff. These nurses and any new staff we may employ are asked to keep in touch with the Clubs, in an effort to keep staff up to date in the modern approach to nursing.

Midwifery Service

To provide a domiciliary midwifery service adequate for the needs of the area is an ever increasing problem. The domiciliary confinement rate during 1968 has fallen to its lowest ever level 19%. This was associated with a reduction in the birth rate in the county to 15.1 live births per thousand population.

TABLE 1

Live and Still Births

Year		Total Births	Domiciliary		
			Domiciliary	Institutional	Percentage
1956	...	3,841	1,584	2,257	41
1957	...	4,029	1,473	2,556	37
1958	...	3,886	1,413	2,473	36
1959	...	3,997	1,324	2,674	33
1960	...	4,046	1,225	2,821	30
1961	...	3,937	1,128	2,809	29
1962	...	4,136	1,148	2,988	28
1963	...	3,996	982	3,014	25
1964	...	4,215	888	3,327	21
1965	...	3,968	711	3,257	18
1966	...	3,719	561	3,158	15
1967	...	3,662	428	3,234	12
1968	...	3,448	301	3,147	9

A breakdown of the home confinement situation in 1968 into areas is as follows:—

Northern Area	...	...	10%	(12%)
Western Area	...	...	6%	(9%)
Southern Area	...	...	10%	(14%)

The figure in brackets is that for 1967.

Year after year it becomes plainer to us all who are trying to run this service that the only satisfactory method of doing so is to have a unified obstetric service, hospital and domiciliary.

The domiciliary midwives working in family health care teams are the best able to undertake the antenatal and post natal care of all expectant mothers. It is to the family doctor that mothers turn first of all for medical care and advice during the antenatal period; it therefore seems logical and sensible for the domiciliary midwife who is working with the general practitioner to give the necessary antenatal nursing care.

During 1968, 701 expectant mothers were given antenatal examinations by domiciliary midwives at antenatal clinics held either in general practitioner surgeries, or county clinic premises but only 282 mothers attended for post-natal examinations at these special clinics. The number of antenatal visits paid to mothers in their own homes was 5,066—an increase of 880 over last year's figures.

During the antenatal period the domiciliary midwife has a great deal to offer, often knowing the family and being in a position to give the environmental history of the mother. No one would deny that during this period there can often be emotional stress and strain and the general practitioner and the midwife together are surely in the best possible position to recognise any deviation from the normal pattern of behaviour and offer advice and help. This is perhaps already recognised as most patients attend the hospital antenatal clinic once in the early stages of pregnancy to book a bed and then do not attend the hospital again until the thirty-second week, leaving the greater part of the antenatal care in the hands of the general practitioner and the midwife working with him.

TABLE II

	1960	1961	1962	1963	1964	1965	1966	1967	1968
Domiciliary									
Midwives	74	66	73	74	69	49	40	36	36
Full-time									
Equivalent	44	39	44	43	22	19	14	13½	11½
Institutional									
Midwives	42	44	53	55	60	59	50	53	56

Table II shows that the number of domiciliary midwives employed in the county has remained unchanged at 36 since last year, but the full time equivalent figure has dropped to 11½. Of the 36 nurses practising domiciliary midwifery only two were working full time at the end of 1968 and this figure will be reduced to 1 early in 1969; 34 are employed as midwives with other duties either health visiting or home nursing.

The midwives paid 5,736 visits to patients who were confined at home which is a decrease of 1,781 visits from the 1967 figure. The number of visits paid to mothers who were discharged before the tenth day increased, however, to 3,866 from 3,225 in 1967; of this figure 112 were paid to patients discharged within 24 hours, and 949 to patients discharged between the third and eighth day.

Two births took place in ambulances during 1968 which is a reduction of three from the previous year. On one occasion the domiciliary midwife was contacted by telephone and travelled in the ambulance to the maternity hospital, but the baby was born before arrival. In the other case, radio contact was made with the hospital and hospital midwives were present at the delivery.

Three additional radios were fitted to midwives' cars during the year, so that 12 midwives now have immediate contact with ambulance stations.

I now quote from reports I have received from two of the domiciliary midwives working in the county, as part of family health care teams. Their comments reflect the variation in viewpoint of different midwives, while indicating a healthy and positive general attitude to the changes which are upon us.

Mrs. D. M. Lancaster, who works in the Northern area comments:—

"The antenatal care given in the doctor's surgery by doctor and midwife I welcome, as we are now able to give health education not only to domiciliary but also to hospital booked patients in the **early** months of their pregnancy, particularly with regard to diet. In the past I feel this has been given too late in pregnancy and in some cases not at all".

Mrs. V. N. Wrightson, whose work is in the southern part of the county, gives an account of some of the difficulties experienced by the domiciliary midwife when visiting mothers discharged from hospital:—

"Early discharges from hospital continued to increase, but only a small percentage of these were home within 48 hours. We hold three antenatal clinics each week and at two of those doctors are present. The home confinements, despite shaking of heads of 'those in authority', were enjoyed by mother and midwife.

"However, many criticisms may be made about the early discharges. So many mothers arrived home after the seventh day, established in a routine set for them in hospital, and not really requiring the services of another midwife. So often it takes a day or two to find these mothers. They seem to be out when one calls, or have gone to stay with a relative without giving any notice of the change in address. A great deal of effort goes into what often turns out to be a five minute social chat offering no stimulus to the midwife at all. Those discharged after 48 hours, one feels, could provide more interest especially if instead of meeting the mother for the first time when she arrives home from hospital, as is the case in this area at present, we were to follow her through the antenatal period, and so were able to form some sort of relationship before the delivery.

"It would seem that these early discharges will form a large part of the midwives' work in future, and with an improvement in communications, I think that this could be interesting and give satisfaction. An extension of the midwives' duties to cover the first six weeks of the infant's life would be an interesting and stimulating development. I think that this could compensate to some degree for the lack of actual home confinements. If this idea was ever implemented I do think that extra training in infant care would be necessary. It certainly is lacking at present, the emphasis is on the mother rather than the baby. As for the hospital midwife conducting the home confinement, it seems to me to be not a question of her skill but of her desire to come out on to the district. With all due respect, so many midwives seem almost to shudder at the thought of delivering a baby without support of the hospital machine around her".

Over the past year there has been a further decline in the number of high risk bookings for home confinements. During 1968, 32 patients refused hospital bookings, mostly for family reasons—"worried about leaving young family at home"—"does not like hospital, lost first baby there".

The number of 'high risk' patients on age and parity alone booked for home delivery in 1968 was 32, a reduction of five compared with 1967, and only 50% of the figure for 1966. Three of these mothers were admitted to hospital.

Patient A, aged 40, having a third baby and suffering from toxæmia at the end of the pregnancy, was admitted to hospital and had a normal delivery five days later.

Patient B, aged 25, primigravida but with only two months antenatal care had a delay in the first stage of labour due to the foetus being in a persistent posterior position, and was admitted to hospital.

Patient C, aged 21, having her second baby after having had a miscarriage in her first pregnancy, had a normal delivery at home but half an hour after the delivery she had a severe post partum haemorrhage which necessitated calling in the flying squad. After emergency treatment the mother was taken to hospital for further blood transfusion.

There is still cause for concern where cases which should unquestionably be confined in hospital have been booked for home confinement.

The excellent relationship between general practitioner and domiciliary midwife in family health care teams should help greatly in reducing this problem.

The most serious problem in domiciliary midwifery in this county is now the danger of the midwives losing their technical skills because of the few domiciliary confinements. The answer seems to be to ask the hospital to act as agents for the local authority in home confinements, the domiciliary midwife then specialising in ante and post-natal care, increasing their participation in relaxation and parentcraft sessions and the encouragement of mothers to attend for the important postnatal examination.

Notification of Congenital Abnormalities

The scheme inaugurated by the Ministry of Health in 1964 for the notification of all congenital malformations observed at birth has continued to operate throughout 1968, the main body of information coming as previously from the maternity hospitals. Fluctuations from year to year in the numbers of congenital malformations notified has repeatedly given me some anxiety as to the comprehensive nature of the cover of this matter. The total figures for 1968 was 56 compared with a figure of 68 the previous year and I once again discussed with hospital colleagues at local maternity liaison committees the mechanics of ensuring comprehensive notifications. Clearly unless this is achieved the value of the scheme in pin-pointing at an early stage the appearance of new types of patterns of congenital malformations would be lost. This was rather underlined in February of 1969 when an investigation by the General Register Office was published based on notification of one of the most obvious gross congenital malformations, namely anencephaly. It was shown that in some areas comparison of returns of deaths from this cause with notifications under the present scheme indicated a disturbing discrepancy. A detailed analysis of how Cumberland stands in this matter is at present proceeding and will be fully discussed at forthcoming maternity liaison committees in the county. The following table shows the cumulative figures since notifications commenced in 1964.

			Males		Females		Total	Total
			Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
Total cases notified	...	...	129	20	117	34	246	54
Central nervous system	...	...	23	19	28	31	51	50
Eye, ear, etc.	...	...	3	—	2	—	5	—
Alimentary system	...	...	15	—	13	2	28	2
Heart and great vessels	...	...	6	—	5	—	11	—
Respiratory system	...	...	1	—	1	—	2	—
Uro-genital system	...	...	25	—	1	—	26	—
Limbs	...	...	43	—	48	—	91	—
Other skeletal	...	...	4	—	1	—	5	—
Other systems	...	...	4	—	7	—	11	—
Mongolism	...	...	3	1	8	—	11	1
Other malformations	...	...	2	—	3	1	5	1

Prematurity

A premature infant is a live born infant with a birth weight of 5 lbs. 8 ozs. (2.5 kilogrammes) or less. The percentage of premature live births of total live births is 6% as in the previous year. Premature births notified during 1968 are set out below with the previous four year's figures for comparison.

1. Number of premature live births notified:—

	1964	1965	1966	1967	1968
(a) in hospital	224	196	218	222	212
(b) at home	22	17	22	10	19
(c) in private nursing homes ...	—	—	—	—	—
	246	213	240	232	231

2. Number of premature stillbirths notified:—

(a) in hospital	42	51	34	51	31
(b) at home	4	3	3	3	1
(c) in private nursing homes ...	—	—	—	—	—
	46	54	37	54	32

There was a total of 20 premature babies born at home during 1968 compared with 13 during 1967, of these 16 survived.

The figure which I found rather disturbing in the above statistics on prematurity is the number of premature live births occurring at home. This was 22 in 1964 when there were 888 domiciliary births. In 1968 the figure is 19 associated with 301 domiciliary births. I feel that this rather indicates that something further still could be achieved in terms of the selection of those mothers for hospital confinement whose medical or obstetric history places them in the "at risk" category, although the figures quoted on page of this report do show that there has been a steady reduction in the number of "at risk" mothers confined at home.

Premature Births

LIVE BIRTHS

Stillbirth

Weight at Birth	Born in Hospital				Born at home or in a Nursing Home Nursed entirely at home or in a nursing home				Born at home or in a Nursing Home Transferred to Hospital on or before 28th day				In hospital	At home or in a Nursing Home
	Died				Died				Died					
	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	
1. 2 lbs. 3 ozs. or less ...	7	6	1	—	—	—	—	1	1	—	—	4	—	
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	23	6	—	—	—	—	—	1	—	1	—	9	—	
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	38	1	2	1	—	—	—	2	1	—	—	12	1	
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	45	1	3	2	1	—	—	3	—	—	—	1	—	
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	99	1	3	1	10	—	—	1	—	—	—	5	—	
6. Total ...	212	15	9	4	11	—	—	8	2	1	—	31	1	

Health Visiting

Over a hundred years ago health visitors were coping alone trying to carry out health teaching amongst terrible disease and poverty to the special group of mothers and babies. Today in Cumberland they are members of a highly professional team, carrying out health teaching and giving social advice and support to all members of the community. Problems have changed over the years and the health visitor must now, with her other medical and nursing colleagues, face new diseases which affect the health and happiness of their populations. The new killing diseases are cardio-vascular, malignant, and cerebro-vascular diseases, accidents in the home and on the road.

Some diseases may not kill but cripple the individual enough to stop him leading a useful and contented life: I am thinking particularly of the psycho-somatic illnesses which affect at some time or other large proportions of our population.

Glancing at the past, Miss E. Mercer writes:—

“In 1942 one day per week was taken up entirely by chaperoning children for examination by the Eye Specialist and the Ear, Nose and Throat Specialist. The time in between these sessions was used in doing the clerical work necessary in preparation for the following week's clinics—always assisted by the appropriate ‘bus and train timetables. Looking back one realises what a waste of a health visitor's day that was”.

The health visitors in Cumberland since their integration into general practitioner led family health care teams have gradually become involved with many different age groups and some interesting pilot schemes have started to which I will refer later.

The involvement with mothers and young children has also broadened enormously to include health care to the whole family. The Sheldon Report—on the future of child welfare clinics—suggests that the health visitor has a unique part to play in the detection and management of emotional illnesses. She is observing throughout young life the physical milestones so that if anything is amiss either physically or emotionally the condition may have

expert referral before the start of school life. It is the secure and happy family which produces the stable individuals in our society and it is worthwhile meditating on the fact that the problem child under-five may be the problem school child, suffer from mental disease in middle life and become a geriatric problem later.

The health visitors by their selective visits to families at risk—especially the teenage parents, parents with known mental disease, etc., do help to teach and support, and in some measure ‘nip in the bud’ these future problems.

Some health visitors are involved in antenatal teaching and parentcraft classes and this would seem an ideal opportunity, not only for teaching, but also to produce a good “working” relationship with these mothers. It is hoped these classes will increase and that the fathers may be persuaded to come along for some of the sessions.

Pilot schemes have been started this year in 13 general practices in an effort to screen ‘at risk’ age groups for cancer of the cervix. These clinic sessions have uncovered many unmet needs and anxieties in women, often in the middle age group, and health visitors have been able in many instances to allay some of these fears, and in others to refer the patients to the family doctor for medical care. Here again we hope that in 1969 this service will grow and many more women will have this valuable test—a more detailed report will be found elsewhere in the text.

Obesity is a problem of western society and a problem health visitors must tackle as a preventive health measure against many of the heart, arterial and joint diseases which accrue from carrying around several extra stones in weight. Two health visitors have continued their weight reduction sessions during the year. These take place alongside treatment prescribed by the family doctor and have managed to give new life and vitality to some overweight patients. This is not an easy problem and, along with excessive cigarette smoking, presents all of us with the immense task of trying to change lifelong habits, or of giving strong personal support when the psychological prop of overeating or smoking has gone !

Three more interesting pilot schemes have started in 1968 and these are concerned in health screening of the older age groups. The health visitor has taken from the doctor's age/sex register, all the patients who have attained their 75th birthday this year. These people have been visited and any physical, psychological or social needs have been assessed and the necessary referrals for treatment or aid carried out. Many of these visits have been most welcome and some have obviously uncovered unknown needs in this age group. It is hoped to extend this service to all practices and to the under 75s in the future.

Health visitors are continually meeting new needs and trying to adapt their health teaching and support to include these new problems. Not only are they working closely with their doctor and nurse colleagues in the community, but also with social welfare workers both in the community and in the hospital setting. We look forward to an even closer liaison with our hospital colleagues and the involvement in pre and post hospital care with the accompanying support of patients and their families which these situations demand.

	1968	1967
Visits to babies and children under 5 years	49,801	53,058
Visits to patients with mental disease ...	784	550
Visits to other age groups	4,148	2,670
Visits to patients over 65 years	17,001	14,519

It is interesting to see not only the increase in home visits paid by the health visitors but also the obvious involvement in other age groups in the practice population, including of course the elderly which is expected.

One health visitor attended a weekend conference at the National Childbirth Trust in London, and another attended a course at Underscar, Keswick, on the care of the elderly. Other health visitors were able to attend some of the lectures on this course. This is very little in the way of refresher courses for these nurses but due to the economic climate it has been impossible to do more.

Group meetings were held throughout the county to discuss the new district nurse and midwifery trainings. The Sheldon Report was also discussed and this is mentioned in the section on Child Health Centres.

Two large meetings of health visitor staff were held when I discussed changing patterns of community care, the Green Paper and the Seeborn Report. At the same time the dental officers talked to us on the vexed but vital subject of dental caries, the prevention or early treatment of caries in young children and dental care for the antenatal mother.

In 1968 the health visitors become 'essential car users' and now have a car allowance on a par with their other nurse colleagues.

There is one health visitor scholarship awarded in 1968; the student health visitor is still under training at Bolton College of Further Education.

The early experience of a health visitor in integrating into a practice team of nurses, is described by Miss I. Arnott who writes:

"Perhaps one of the drawbacks at present is lack of space in most surgeries and while the situation exists that the health visitor spends quite a lot of working time at another base, e.g. clinic for clerical and report work and just calls in, albeit daily, at the surgery she is losing what might be a valuable contact and availability to deal promptly with various queries connected with her sphere of work which arise from patients' visits to the doctor".

From Millom the health visitors' report gives us a glimpse of the setting in which their work is at present carried on—a situation of extremely high unemployment. No one more than the health visitor needs to be sensitive to community circumstances.

They write:—

“Due to the unemployed being on full social security benefits monetary problems have not arisen so far, although we can quite foresee problems of split families such as old people being left behind when young people seek other places of employment. Another problem in this isolated part of the county is the financial difficulties of hospital visiting due to the distance involved. By working with a group practice, as in Millom, and our interchange of information between the practice team, we have a full spectrum of the whole town”.

Many nursing students have visited us during the year and have expressed great interest in our conception and practice in the field of community health teams. These included:—

- 12 student nurses from the Cumberland Infirmary.
- 9 health visitor students, Bolton Technical College (one of these from the U.S.A. and one from Africa).
- 1 health visitor student, U.L. County Technical College, Surrey.
- 2 nurse administration students, William Rathbone Staff College.
- 1 community nurse student, Manchester University
- 1 social administration student, Manchester University.

We were also honoured by visits from national and international nursing and medical personnel. We think they were impressed by the service we give to our communities. The visitors included senior nursing officers from the Department of Health and Social Security, Central Midwives Board, the Welsh Board of Health, the William Rathbone Staff College and Buckinghamshire County Council. In the international field our visitors included senior nurses from Norway, Denmark and Iran and a W.H.O. fellow, from the U.S.A. We have also been very pleased to welcome our medical and nursing colleagues from across the Scottish Border and our hospital colleagues from Carlisle.

Health Education

In Cumberland during the year, 680 lectures have been given covering over 30 different health educational topics, ranging from general body hygiene to baby feeding, foetal development, normal delivery, cigarette smoking, accidents in the home, etc. Fifty-three discussion groups have also been held in the county and lectures given by senior staff to various professional bodies on the health and welfare services provided by the county.

Health education sessions:

247 in schools

62 in clinics

264 in relaxation clinics

50 in mothers clubs

57 others

Total attendances 11,880

Much personal health education is, of course, given by all the public health nurses in their day to day contact with the families and patients they visit. Many find this a better method than formal teaching—giving as their reason that the health education can be geared to a particular need and appropriate to the family circumstances.

The following extracts help to illustrate the tremendous age range which is covered by our health visitors in the field of health education.

Miss E. J. Surtees, who organises weekly meetings of the Mothers' Club, at Park Lane Clinic, Workington, offers the following comments:—

“From a wide variety of informal discussions at the Mothers' Club, it is being observed that knowledge has given confidence and appears to have influenced an increasing number of mothers, making them aware of such matters as dental care, correct footwear, care of children's feet, in fact, family health as a whole.

"Other activities of the Club have included nutritional quiz and competitions and a film 'Sex education for eight-year olds' was received with appreciation.

"Some members rarely miss an evening at the Club and mothers especially those with young children remark on the mental refreshment they get from fellowship with other people, and adult conversation. To encourage social integration other club members are invited on health education nights and special evenings".

Mrs. M. Hewitson, health visitor, writes:—

"The district meeting of Scouts and Cubs invited me to speak to a group of about 100 on Home Safety. The Co-operative Women's Guild asked me to speak one evening on Health Education in schools. Many of these ladies were the mothers of the children whom I teach, and amongst other illustrations I was able to demonstrate the type of material we use in school.

"Harrington Over-60's Club also invited me to speak last February, and to a crowded hall of over 70 men and women I gave a talk on Home Safety illustrated by flannel-graph. Last October I was again invited and to an even bigger audience showed the film 'Growing Old'. After the film the members decided they should look out for old people in need—like those in the film, and report to the Club Committee if worried about anybody".

Mrs. M. E. Fleming, President of the Ladies' Social Club, Longtown, has written as follows:—

"I am very happy to report that the Ladies' Social Club Meetings held fortnightly in our splendid new clinic are most successful, being well attended by wives and mothers of all ages who mix extremely well.

"There is a varied and interesting programme for their instruction and pleasure. For example, recently we had lectures by Dr. Elderkin on the prevention of childhood illnesses;

a marriage guidance counsellor talked about the work of the Marriage Guidance Council, and Mr. Parsons gave a talk on dental health. Other speakers included a Social Welfare Worker from Coledale Hall, and Miss Butler, health visitor, who talked about cytology, venereal disease and breast cancer.

"Arrangements have been made for Dr. Bentley to lecture on drug addiction, Mrs. Perrott on Dr. Barnardo's Homes, and Miss Butler on natural childbirth, in the near future.

"In a somewhat lighter vein we have cookery demonstrations, how to care for your figure, talks on hair fashions, beauty care, and flower arranging".

Yet another health visitor in the Cleator Moor area, Miss R. Sheppard, reports:—

"Special discussion groups are held, related to the needs and knowledge required by young people. The topics for discussion include alcoholism and its effects on people, drugs and the effects on family life, sex education and budgeting including hire purchase. The school children enjoy someone other than the usual teacher, and the school nurse may have other experiences which the school child can appreciate as valid. In so doing, she is able to provide a contact with the community services for the child and sets values which may be discussed.

"From the school nurse's point of view, the work is interesting and gives her a better liaison with the rest of the school staff.

"Health education in schools is particularly useful in helping personal relationships and talking over with a group why some people act as they do and even helps the teenagers who are often quite surprised to realise that grandma really cares about their welfare when she will not allow staying out late".

The World Health Organisation's description of health is 'a positive feeling of mental and physical well being'.

I feel there is a great need to expand this field of health teaching, so that we may have a better informed community on all aspects of good health—mental, physical and spiritual. This will require great team work between all sections of the Health, Welfare and Education Departments so that nurses, teachers and social workers may all play their part in not only teaching but counselling all age groups, not just in one particular aspect of health, but broadly seeing the needs for the 'whole man'.

HOME HELP SERVICE

Section 29 of the National Health Service Act, 1946

“A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, aged, or a child not over compulsory school age, within the meaning of the Education Act, 1944”.

HOME HELP SERVICE

In basic ideas and principles there was little new in the home help service in 1968 although there is a constantly changing reaction of the patients to new situations.

The home help service is undoubtedly most essential in this era of community care, particularly to the elderly, if their needs are going to be fulfilled. So often the main desire of the elderly is to stay as long as possible in their own homes, with their own personal possessions around them, in the environment where they have usually lived for many years. Almost the whole purpose of the service must be to assist them in every way to do this.

During the year under review the total number of households assisted by home helps was 1,346, an increase of 22 on the previous year. Of those helped, 1,132 were persons aged 65 years or over. This is 84% of the total compared with 80% in 1967. How the overall work of the service was divided between the three areas of the county is indicated in the following table.

Area	No. of Households assisted	No. of Home Helps
Northern	399	118
Western	505	72
Southern	442	72

The different ratios of home helps to households in the various areas is due to the density of population and the public transport facilities. In the very rural northern area it is commonplace that a home help can only serve one household whereas in the more urban western area home helps can frequently serve many households within a very small radius.

The table printed on page — illustrates how the number of home help cases coming within the categories of elderly, maternity and other illnesses has varied over the years. The proportion of the cases within the category of maternity has now become almost insignificant at slightly less than 2%. Most of those cases were in the northern area of the county, the main rural area. At 14% the cases coming within the category of "other illnesses" is back to the 1966 figure after increasing to 17% in 1967.

HOME HELP CASES

I am very pleased to be able to report that during 1968 the majority of the service was further increased by the purchase of another van, making a total of three in the county. There is now one home help van based in each area but, in addition, there are six home helps who drive their own cars, four of them in the northern area and two in the southern area. Many households in the county could not have the benefit of the home help service if the vans were not available and, during the course of the year, 59 households were assisted in this way. Here are the comments of a home help in the south of the county who drives one of the vans:—

“The van has proved invaluable in times of illness. In more than one case I have been able to 'phone for the doctor and wait until he arrived. This seems to give the poorly person great comfort just to have someone there they know. I have been able to go back later in the day and pay more visits to help out. This I could not possibly do without the van.

On another occasion I was able to go and find relatives belonging to an old lady at Ulpha (an isolated village on the Lancashire border and about 10 miles from the nearest Cumberland town of Millom). She was ill and could not remember where her relations lived.

I have been able to bring urgent tablets, etc., from the doctor and the chemist and there is never a week goes by but what I bring all kinds of shopping for the isolated people. In the country areas their shopping is very restricted.

I bring the washing home for some. I have the hot water and the equipment here, it is easier for me and far easier for them.

Those I go to away from 'bus routes feel that they are on the map again and tell me it is nice to think they are not forgotten. Sometimes I stay a while chatting for some of these people are terribly lonely and I feel ten minutes

or more (of my own time) before I leave them helps to dispel this terrifying loneliness and puts them in a better frame of mind. The very fact they think somebody cares and is interested enough to listen to them helps tremendously."

One aspect of the service which is not usually heard about is the provision of resident home helps in special circumstances. During the year six households received this service. They were for midwifery cases and to provide temporary full-time help in crisis situations with the care of the elderly until alternative support could be provided.

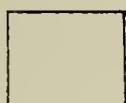
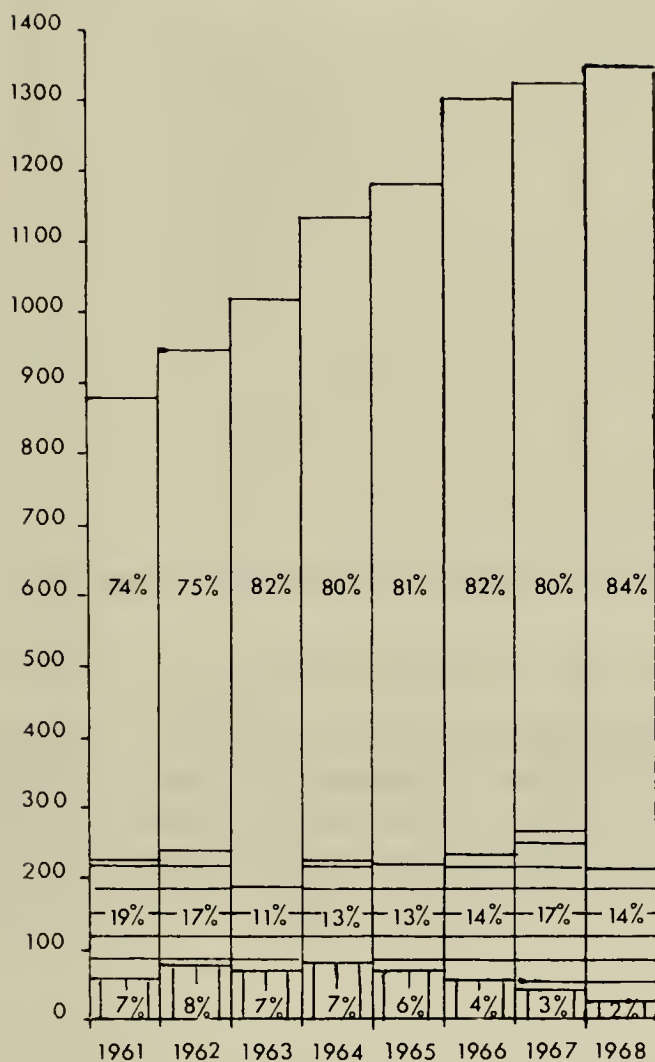
The sporadic need for help and guidance for the families with special difficulties arose on only two occasions. Specially selected home helps were used but, as is usual in such cases, it is difficult to assess whether any lasting benefit has been achieved. I believe that it is an effort which must, however, be made.

The Marie Curie Day and Night Nursing Service has been available in the county for some years and it is surprising that there is not a greater calling for its use. Only four households took advantage of the night sitting service yet it is known that 362 patients suffering from cancer were, in fact, nursed at home during the year and that those involved a total of 9,861 visits by the domiciliary nursing staff. The availability of the Marie Curie Service is brought to the notice of the relatives in all these cases but it seems that almost always people wish to look after their own relatives if they are at home in the terminal stage of malignant diseases, however much the strain of doing so.

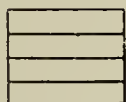
With the development of health centres in the foreseeable future it is envisaged that the home help will become a member of the family health care team. Already this is happening to a limited extent as one home help reports:—

"There is great team spirit between our general practitioner, health visitor and nurses, and being home helps in this small country town we feel included in the team. Any worries which we have about our cases can be reported at once and dealt with."

HOME HELP CASES



Elderly



Other Illnesses



Maternity

CARE OF MOTHERS AND YOUNG CHILDREN

Section 22 of the National Health Service Act, 1946

“ It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority.”

CARE OF MOTHERS AND YOUNG CHILDREN

Once again this year this section of the report centres mainly on child health centres, dental services for mothers and young children, the work of the marriage guidance councils, family planning service and care of the unmarried mother and her child.

Care of the Unmarried Mother and Her Child

The setting in which the County Council contributes to the welfare of the unmarried mother and child is admirably described by Miss J. C. Pochin, Organising Secretary of the Carlisle Diocesan Council for Social Work, in the following comments on her work, which she has kindly contributed for this report :—

“ The death-rate among illegitimate babies is consistently higher than that for those born in wedlock, and unmarried mothers are regarded as being at risk from a gynaecological point of view. Even so, the social, practical, economic and emotional difficulties are more conspicuous than the medical ones. How will the mother manage financially while she is unable to work ? Where shall the confinement take place ? What will be the attitude of her family, and—most important of all — shall she bring up the child herself or is he to be offered for adoption ?

When the pregnant girl seeks the help of a social worker the worker's general attitude and approach to the client and her problems are no less important than the solutions found for them, and may greatly influence the future stability and happiness, not only of the mother, but also of the unmarried father and their respective parents and families.

The Carlisle Diocesan Council for Social Work besides maintaining the Mother and Baby Home at Coledale Hall, Carlisle, and the Maternity Home at St. Monica, Kendal, has also four caseworkers who are experienced in these situations, two of whom serve the Cumberland County area : Mrs. M. V. Kenyon, based on Whitehaven, and Mrs. M. J. Rudd, of Carlisle, who covers North and Mid Cumberland.

In 1968 they noted an increase in the number of young people who, firmly intending to marry when they can afford to, and therefore faced with a long engagement, nevertheless do not wait to have a baby. Since they are not in a position to marry immediately and in any case have nowhere to live, it would generally appear to be in the child's best interests for him to be adopted, but the predicament is a complicated one.

The single woman of low intelligence who has three or four children presents a very different picture. She is not usually capable of managing the pill, but in 1968 a few have been fitted with contraceptive devices, and this would appear to be helpful.

The acute shortage of suitable living accommodation for unmarried mothers who keep their babies causes real hardship. Efforts are being made to find a practical way of meeting the need.

An efficient casework service for unmarried parents requires the participation of many different departments. We look forward to even closer co-operation when the Seebohm Report is implemented."

Since the authority's primary financial commitment in this field is the support of those unmarried mothers for whom a stay in a mother and baby home seems desirable, as well as the contribution of an overall grant to the Carlisle Diocesan Council for Social and Moral Welfare Association, it would be well to note briefly one or two quantitative factors in the situation.

The difficulties associated with the unmarried mother and her personal complexities are still however very much in evidence, with the number of illegitimate births in the county during 1968 totalling 207.

As the following table shows, the rate of illegitimacy in the county is generally on the increase but is still well below the rate for England and Wales:—

	Administrative County Rate per 100 total live births	England and Wales Rate per 100 total live births
1962	4.6	6.6
1963	4.9	7.4
1964	4.7	7.8
1965	5.6	7.7
1966	5.8	7.9
1967	6.6	8.4
1968	6.0	N/A

Problems and difficulties associated with the unmarried mother and her child are now coming more within the sphere of the social welfare worker. Once again I am able to report that the number of admissions to mother and baby homes is relatively low and gives some indication of the changing community and family attitudes. This is borne out by the following table which gives the number of unmarried mothers over the last five years, for which the County Council accepted financial responsibility in a Mother and Baby Home as a percentage of the illegitimate babies born in Cumberland.

1968	1967	1966	1965	1964
12.1	10.1	19.5	22.1	20.9

Next year I hope to see most if not all unmarried mothers in the county taking advantage of the specialised care and modern techniques of the maternity hospital, as it is known that nearly all these mothers are in the high risk category for one or more reasons.

The work of the Moral Welfare Associations is supplemented by the financial help given by the local authority towards the upkeep of this minority of mothers during their stay in the mother and baby home, and the following table shows the age groups of the 25 mothers for whom the County Council accepted financial responsibility during 1968. The table also gives comparative figures for the last five years:—

	1968	1967	1966	1965	1964
15 years	—	1	—	1	4
16 years	2	2	3	6	3
17 years	1	2	10	6	4
18 years	4	4	5	13	5
19—24 years	15	13	18	31	21
25—30 years	2	1	4	2	1
31 years and over	1	1	2	1	3
	25	24	42	60	41

The large majority of Cumberland's unmarried mothers who were accommodated for a period in a mother and baby home were in fact in Coledale Hall, Carlisle. This home has been progressively upgraded in amenities and attractiveness over the past five years. Miss Wilson, the Matron, took up her duties on 1st April, 1967, and I am grateful to her for the following comments on her work hitherto :—

“Residential Care of the Unmarried Mother and Her Child. In 1885 Miss Burton started a Home for girls who needed care and shelter, on the corner of Burgh Road. This was run by a Church of England Order and called St. Mary's Hostel. The purpose of running this Home was to take in laundry so giving the girls employment and training.

St. Mary's Home and Laundry was later given up but in 1925 the North Cumberland and Carlisle City Social and Moral Welfare Association acquired the tenancy of Coledale Hall; this became a Shelter and Mother and Baby Home. After several years, in 1961, on the advice of the Health Authorities, St. Mary's Home (known as Coledale Hall) became a home for pregnant girls only. It offered a Home for approximately six weeks before the confinement and six weeks afterwards, for the less secure girl who welcomed community life and who needed skilled casework help and loving understanding from a trained social worker and her staff.

The Home will take an extra-marital client, or a girl expecting a second or third baby or an older woman of 40 years or more.

At one period in 1967 Coledale Hall had 6 girls of 16 years of age and under. The question then arose of education for these young girls, and after applying to the Education Authority we were able to have a Home Teacher to visit Coledale Hall on Tuesday and Friday of each week.

In the case of the schoolgirl mother entering the Mothers and Baby Home, while her parents get over the emotional tensions and adjust themselves to the shock and accept the girl's condition, the girl is herself a schoolgirl; she is a child; she is adolescent; she is pregnant; but is also faced with the problem of growing up and she needs a great deal of casework support.

What of the putative father? Where there is a deep tie between the girl and boy responsible, he should be allowed to visit the Home; perhaps in the future a marriage will take place, making a natural home for the child.

He also needs considerable help, together with his family, and we must be truly compassionate in our approach to the situation.

The clients come from a cross section of the community: the mentally backward; the factory girl; shop assistant; office girl; student; teacher and nurse. The trend at the moment seems to be the less intellectual girl, who does not bother to think of abortion, or leaves it too late.

The Health Visitor visits the Home once a week, teaching the girls relaxation exercises and explaining to them about the birth of their baby.

The confinement takes place in the City Maternity Hospital; where they are taken by ambulance accompanied by a member of staff, returning with the baby after approximately six days. The mother is then taught the modern method of caring for her baby.

The Chapel plays an important part in the house. Here we have homely family prayers, when we remember our baby homes and parents. Quite often girls who decide to keep their babies have them baptised before leaving the Home. We hope the time spent in the house will offer a positive experience, which will make the residents better able to face life in their own environment on leaving.

In the last six months we have worked closely with the Local Authority in placing babies for adoption ; and we look forward to continued co-operation with the Children's Departments and also our Medical Officers of Health.

We are hoping that it will be possible, some time in the future, to have in our county semi-sheltered hostels and bed-sitters for mothers who wish to keep their babies."

It was only after many meetings and much careful deliberation that the County Council decided no longer to participate in the financial arrangements, previously shared with Carlisle County Borough Council, Westmorland County Council, Barrow-in-Furness County Borough Council, and Lancashire County Council for the running of St. Monica's Home, Kendal. While this Home continues to be run with a degree of dedication which is beyond reproach and a high quality of personal care by the professional workers, the principle of the confinement of mothers, almost by definition in the high risk category, in any but a hospital obstetric unit, became crucial. I am sure the authority's decision was wise to make it a matter of policy that these confinements should be in hospital. The small extra number of unmarried mothers requiring hostel accommodation has been adequately arranged at Coledale Hall, Carlisle, from where the mothers are admitted for confinement to the City Maternity Hospital, Carlisle.

Distribution of Welfare Foods

Local authorities have a statutory duty to distribute welfare foods on behalf of the Department of Health and Social Security.

The continuing reduction in the sales of welfare foods can be attributed to several factors such as the declining birth rate and the rise in recent years of the family income, together with the wide choice that mothers have of different brands of dried milk and vitamin extracts on the commercial market. Perhaps the most important reason is that maternity hospitals in this county are using proprietary dried milk for baby feeding, which means that when the health visitor sees the mother and baby after discharge at either clinic or home, feeding and the choice of food have been firmly established.

The recent report of the Sub-Committee on Child Welfare Centres (Chairman, Sir Wilfred Sheldon) recommended that "National dried milk and proprietary infant foods and cereals need not be purveyed at child health clinics. If the local health authority wishes to continue to make these commodities available, this should be organised as a separate activity." In the light of this report, it seems evident that the future trend will be for the sale of these foods to be carried out as a separate activity away from the welfare clinics and at various distribution points throughout the county.

It is doubtful whether, in fact, the sale of welfare foods is an important factor in attracting mothers to the clinics. Statistics shown elsewhere in this report indicate an increasing use of clinics held in general practitioner surgeries where welfare foods are not sold.

The Sheldon Report states that, "500 mothers were interviewed at clinics throughout Cumberland. These mothers were asked why they first came to the clinic. 34% said they came to the clinics for advice and re-assurance, 27% had been recommended to attend, 22% attended to have the baby weighed, 6% for injections and 3% to obtain cheap foods." This small percentage of 3% is still provided for however by services administered

rough the area medical officers. Even the most remote parts of the county are covered by a network of 92 distribution points at which welfare foods are available. In many cases the work of distribution is being done by the Women's Royal Voluntary Service, the members of which have carried out their duties during the past year both exceedingly conscientiously and expeditiously.

The following table gives a comparison of the sales of welfare foods over the past ten years :—

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin Tablets (Packets)	Orange Juice (Bottles)
1959	105,984	15,350	7,076	93,684
1960	92,676	14,961	7,475	90,343
1961	78,155	9,067	5,017	50,653
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,943
1964	74,886	4,909	2,236	36,389
1965	78,047	4,636	1,881	39,053
1966	74,902	4,326	1,771	41,636
1967	69,460	4,131	1,405	43,459
1968	67,116	3,844	1,138	42,705

Dental Service

The Chief Dental Officer, Mr. R. B. Neal, makes the following comments on the Dental Service for 1968 :—

“ Very little change has taken place during the year, but our programme of re-equipping clinics is proceeding slowly and the newly furnished ones are certainly proving a great help both to operator and patient alike.

One disturbing factor about the health service is the inadequate facilities for the examination and treatment of the severely handicapped elderly and the housebound. The dental officers will always be only too pleased to inspect children in their own homes if the parents are too shy or find it difficult to attend the clinic with the child, but nothing can be done by the local authority to help the aged.

Old age is an ever increasing problem and no provision has been made for domiciliary treatment either by local authority or hospital dental surgeons, and so they are dependent upon the goodwill of general dental practitioners, who, in main, quite genuinely have not the time, neither is it economic for them, to treat patients in their homes. One should be disturbed by this breakdown in total patient care, as it is at the present time.

A qualified dental auxiliary ought to start work in West Cumberland during the year 1969 and this will be a step in the right direction, because no one can treat or educate in oral hygiene the pre-school children as can the auxiliaries. As dental auxiliaries have to work under the supervision and to the written prescription of a qualified dental surgeon, one must plan more two-dentist surgery suites in the clinics and health centres in order that they may be employed over as wide an area as possible.

Except in one or two areas very few maternity patients attend for dental treatment—these areas being where there are few or no general dental practitioners. One is happier about the attendance of pre-school children, although many

parents do not seem to realise that children are treated at the clinics before they start school."

Mr. A. R. Peck, L.D.S., Dental Officer at Flatt Walks Clinic, Whitehaven, makes the following comments on the Maternity and Child Welfare Service:—

"The treatment of pre-school children has followed the usual lines of advice to the mother and conservation and extraction of teeth where necessary. It would seem nowadays that the majority of mothers are aware of the dangers of a sticky sweet diet with resultant damage to the teeth (though not all by any means take notice of it).

What a number of parents still do not seem to be fully aware of, however, is that children can attend the clinic during their pre-school years and that they do not have to start school before treatment is offered. On some occasions mothers have remarked when bringing school age children to the clinic that they had pre-school children requiring treatment and they were not aware that treatment was available for them. Unfortunately the first visit of a number of children is because of toothache and this is hardly the best way to introduce children to the dental surgery.

Maternity cases now, apart from the odd obviously neglected mouth, require normal dental treatment, whereas a decade ago the majority of cases one saw had neglected mouths where the only course of treatment was extractions and provision of full dentures. It is disappointing, however, that a number of cases seen after an interval of several years when another child is expected have obviously not had dental treatment since the birth of the previous child."

Fluoridation of Water Supplies

Five years have elapsed since the County Council approved in principle the fluoridation of public water supplies in this county and it is disappointing that at the end of 1968 no schemes have been brought to fruition. However, it is hoped that by the time this Report is printed there will be two schemes in operation. At the time of writing the equipment is already installed at Gunner-ton by the Newcastle and Gateshead Water Company, whose scheme for fluoridation in South West Northumberland includes two parishes in the Border rural district. The equipment is being tested and is about to be commissioned.

Similarly, the fluoride content of the supply to West Cumberland from Crummock Water is about to be adjusted. This scheme has been carried out by the West Cumberland Water Board in conjunction with the installation of new treatment works and it will serve a population of about 60,000 in the Workington/Maryport/Cockermouth areas.

The West Cumberland Water Board has also agreed to adjust the fluoride content of all its water supplies as opportunity permits but firm dates for work in connection with the Quarry Hill and Hause Gill sources have still to be settled.

The South Cumberland Water Board has agreed in principle to the fluoridation of the supplies from the Ennerdale and Baystone Bank sources. Again, this will be co-ordinated with other work which is to be carried out. It had been hoped that the Ennerdale scheme would have been going ahead before now—it would serve a population of about 60,000—but proposals by the water undertakers to raise the level of the lake have been delayed and it now seems that fluoridation of this particular supply is still some years away.

Over 30,000 county residents live in the area around Carlisle, which comes under the area of the Carlisle Water Board and the recent decision to fluoridate its supplies after earlier steadfast refusal to do so gives rise to optimism.

The remaining water board in the county — Eden Water Board — also decided to take no further action. Again there was another authority involved—Westmorland County Council—which held a different view on fluoridation to Cumberland County Council.

The obvious question in years to come will be whether fluoridation gave the benefits which its supporters claimed for it and to enable the authority to assess the situation the assistance of Professor P. Jackson, Professor of Children's and Preventive Dentistry at Leeds University, was sought. He kindly arranged for a member of his staff—Mr. J. F. Gravely—to examine 100 children in each of the age groups 5 and 15 years in an area of the county where early fluoride adjustment of the content of the public water supply is expected. As a control, a similar number of children in the same age groups were examined in an area which, for technical reasons, is not likely to have such fluoride adjustment for some time. The intention is to carry out similar examinations in both areas in five years time and ten years time, when it is expected that the value of fluoridation to a dental optimum of one part per million will be apparent. I am most grateful to Professor Jackson for his invaluable assistance.

Child Health Centres

Throughout the year meetings have been held with doctors, health visitors, home nurses and midwives to discuss the report of the Sheldon Committee, which was asked to review the medical functions and medical staffing of child welfare centres and to make recommendations.

The old concept of the baby clinic being a place for the weighing of babies and buying of cheap food should give way to a more ordered and professional outlook !

The Sheldon Report saw the continuing need of a preventive service to safeguard the health of children—and hoped it would in future be provided by family doctors, with health visitors working in general practice. Cumberland should, therefore, be in an ideal situation to provide this type of service.

It was felt a new look should be taken of our clinics — to analyse the job which needed to be done in view of present needs and problems in children and their families.

In 1968 a survey was undertaken with regard to the selling of food and the clerical work being carried out in the 31 child health centres held throughout the county. In twelve of these centres baby food was not available but in 19 centres various foods were sold, in a few instances by the health visitor, but at many sessions she was responsible for ordering the stocks and taking care of the money. In practically every session the health visitor was carrying out all the clerical work involved in the running of the clinic.

Has the time come in 1969 for the nursing staff to be completely divorced from food selling and stocktaking in our clinics?

Most of the immunisation and vaccination programmes are carried out in the general practitioners' surgeries by the health visitor or district nurse in the team. Some general practitioners do use these sessions for well baby clinics which seems an ideal arrangement, and I hope that this may become more streamlined

aving the duplication of staffing and visits for the mothers and babies which now exist between the general practitioner sessions and the local authority clinics.

Number of clinics	...	...	...	...	31
Number of G.P. clinics	...	...	...	...	8
Number of children attended 1968	...	...	...	...	36,439
New babies	...	...	...	...	3,086
0 — 5	...	...	...	...	6,264

I should like to pay tribute to the many ladies who come in a voluntary capacity to help in our child health centres, relieving the health visitor of non-nursing tasks and by their friendliness helping many mothers and children to feel at home in the clinic setting.

Miss M. Butler comments :—

“The last summer of 1968 marked the opening of the first ever clinic (purpose built) in Longtown.

It has rapidly become the centre of a vast range of activities in the community and is well appreciated by the people of Longtown.

The child welfare clinics especially benefit from the excellent facilities. The two general practitioners in Longtown alternate a fortnightly well baby clinic and an appointments system reminds mothers of impending routine check-ups. The mothers continually voice their appreciation of the availability of their own general practitioner in the clinic.”

It is very interesting to note how very well these premises are being used and we are now getting away from the concept of a clinic just being used for one or two sessions weekly to including all community needs, and as Miss Butler emphasises in the rest of her report :—

"The handicapped persons' club now enjoys a complete day in the new clinic inclusive of a three-course lunch and afternoon tea. The clinic adapts splendidly to the various requirements of this particular group. We now provide chiropody facilities, once every two months. The services of a physiotherapist fortnightly, a hairdresser weekly, plus the continual contact of the welfare officer and health visitor. And perhaps most important of all the social contact with each other. We have a hard working group of voluntary workers and the services of two senior pupils from Lochinvar School who all help to make this day run smoothly.

Other groups include the ladies' social club who meet every fortnight (in the evening). A pre-school play group holds two morning sessions every week catering for 20 children (we always have a waiting list for this group). Other clinics or classes include cytology sessions fortnightly, relaxation classes weekly, deaf testing sessions monthly and school clinics when necessary. Already it is difficult to imagine how all this was managed in the bad old days before the new clinic was built."

Attendances at Local Authority Child Health Centres 1959-1968

Year		No. of centres provided at end of year	No. of child welfare sessions held per month at centre	No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
				Under 1 year	1 - 2 years	2 - 5 years		
1959	...	22	92	1596	1455	1389	4440	21947
1960	...	22	95	1548	1408	1368	4324	22089
1961	...	23	95	1603	1667	1704	4974	23004
1962	...	27	96	1894	1625	2080	5599	27299
1963	...	29	98	1901	1892	2007	5800	31948
1964	...	30	106	2231	1865	2145	6241	35162
1965	...	31	110	2322	2385	2285	6992	36852
1966	...	33	119	2193	2185	2213	6591	33521
1967	...	33	117	2080	1859	1890	5829	32420
1968	...	32	131	3086	1450	1728	6264	31326

CHILD HEALTH CENTRES, 1968

The following table gives particulars of the sessions and attendances at Child Health Centres throughout the County:—

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Northern Area					
Alston	Cottage Hospital, Alston	Wednesday	50	392	8
Anthorn	W.V.S. Welfare Office, Anthorn	2nd and 4th Thursday	20	230	12
Aspatria	North Road, Aspatria	Wednesday	48	780	16
Brampton	Union Lane, Brampton	Friday	50	1713	34
Dalston	Village Hall, Dalston	1st and 3rd Monday	20	385	19
Houghton	Village Hall, Houghton	2nd and 4th Wednesday	23	413	19
Hunsonby	The Institute, Hunsonby	1st and 3rd Thursday	19	436	23
Longtown	Esk Street, Longtown	Tuesday	47	1430	31
Nenthead	Doctor's Surgery	1st Tuesday	12	51	4
Penrith	Brunswick Square, Penrith	Tuesday	50	1483	30
Skinburness	R.A.F. Hut, Skinburness	1st Friday	8	36	5
Scotby	Village Hall, Scotby	1st and 3rd Thursday	24	361	15
Thursby	Church Hall, Thursby	2nd and 4th Monday	23	223	10
Wetheral	Village Hall, Wetheral	2nd and 4th Thursday	23	321	14
Wigton	Birdcage Walk, Wigton	Monday	46	995	22
			463	9249	20

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Western Area					
Broughton	Nurse's House	3rd Wednesday	23	136	6
Cockermouth	Harford House, Cockermouth	Monday	49	1214	25
Crosby, Maryport	Nurse's House, Parkside, Crosby	2nd and 4th Wednesday	—	—	—
Dearham	Nurse's House, Central Rd, Dearham	4th Wednesday	11	161	15
Keswick	13-15 Bank Street, Keswick	Thursday	52	739	14
Maryport	24 Selby Terrace, Maryport	2nd and 4th Tuesday	51	1503	30
Seaton	Miners' Welfare Hall, Seaton	2nd and 4th Thursday	23	688	30
WORKINGTON—					
Park Lane	Park Lane, Workington	Wednesday and alternate Thursday	99	2834	30
Salterbeck	Holden Road, Salterbeck, Workington	Friday	49	1093	22
			357	8368	23

Centre	Address	Day	No of Sessions	Total Att.	Average Att.
Southern Area					
Cleator Moor	Ennerdale Road, Cleator Moor	Thursday	52	1274	24
Egremont	St. Bridget's Lane, Egremont	Tuesday and Thursday	72	1586	22
Frizington	Council Chambers, Frizington	Monday	46	908	18
Millom	18 St. George's Road, Millom	Tuesday	49	1605	33
Seascale	Gosforth Road, Seascale	Thursday	354	3805	11
Thornhill	Community Centre, Thornhill	1st and 3rd Wednesday	24	386	16
WHITEHAVEN—					
Flatt Walks	Flatt Walks, Whitehaven	Monday and Tuesday	51	1539	30
Mirehouse	Dent Road, Mirehouse, Whitehaven	Monday	49	1495	30
Woodhouse	Woodhouse, Whitehaven	Wednesday	51	1111	22
			748	13709	18
			1568	31326	19
		GRAND TOTALS			

Family Planning

The County Council have not been able to proceed any further with the implementation of a family planning service called for in the National Health Service (Family Planning) Act 1967. The County Council has agreed in principal to employ the Family Planning Association as its agent for this service, but financial restrictions were again the main obstacle to development in this direction.

The Family Planning Association continued, however, to provide a service, and help from the County Council has continued in the free use of local authority premises and equipment. There are regular clinics at Millom, Penrith, Whitehaven, Workington, Alston and Keswick. There is also a clinic in Carlisle in premises made available by the Carlisle Borough Council, which is attended by county patients living in the surrounding area.

Towards the end of the year local authorities were faced with a new responsibility for the safe keeping of poisons, including oral contraceptives, stored in their premises. Arrangements are at present being discussed with the Family Planning Association as to the best means of meeting these requirements.

Mrs. Thornton, Chairman of the Carlisle branch of the Family Planning Association has the following comments to make on the running of clinics in Carlisle and Keswick:—

“The Family Planning Clinic was rehoused in spacious and pleasant rooms at the Central Clinic, Victoria Place, Carlisle in September, 1968.

The clinic is organised by three layworkers with one doctor and one nurse on medical duties. The clinic consists of a large waiting room (with children's playroom attached), the administrative centre, the interview room and two medical inspection rooms. The 'by appointment' system is in operation and all methods of birth control can be obtained or explained. 81 new 'oral' patients and 56 new 'cap' patients were seen in 1968 in addition to patients paying return or check visits. It is hoped to commence an I.U.D. Centre within the Central Clinic in the near future.

The present I.U.D. Centre (which covers an area from Dumfries to Barrow), is housed in Keswick Cottage Hospital and is staffed by one doctor, one nurse and one layworker. The Clinic consists of a waiting room, an interview room, a sitting room (with bed available) for use of the patients who have been fitted, and a theatre for the fitting of the I.U.D. 137 new patients have received attention at Keswick during 1968—plus the return and check visits. There is, unfortunately, a waiting list of three months for I.U.D. fitting owing to the shortage of medical staff trained for this purpose.

Family planning measures are urgently necessary to solve world population problems. The ideal method is still to be found which is acceptable to the individual couple who are affected not only by cultural and religious attitudes but even more by their own feelings and prejudices. There will probably never be a method which will be acceptable and suitable for everybody, but the Pill and the I.U.D. are the first of the new methods and subsequent progress in this field may require the introduction of methods yet unknown."

Mr. Camm, Lakeland Branch Organising Secretary of the Family Planning Association, reports:—

"There have been a number of changes in the Association during the past year. A system of centralised accounting is now in operation, all clinic accounts being transferred to Branch Office. A 'Good Housekeeping' campaign is being waged with a view to reducing stocks in clinic stores, and negotiations are taking place with manufacturers with a view to obtaining a new national purchase price of goods instead of 'Free Gifts' and 'Bonuses'. The patient must benefit by the eventual reduction in price. Central Office has been organised and is now much more efficient.

In Lakeland Branch it is expected to open an additional I.U.D. Clinic at Carlisle. The forms provided for completion by clinics have been changed to make the work less arduous for layworkers with the result that there will be a reduction in the various headings for statistics for year ending 1969".

An interpretation of the statistics supplied by Mr. Camm shows a general slight increase for sessions and new patients. There is a movement by patients towards newer methods of family planning, an increase in the number of pre-marital consultations, and also an increase in non-Family Planning Association cytology.

Nurseries and Child Minders

The Nurseries and Child Minders' Regulation Act, 1948, placed an obligation on the local health authorities to keep registers

- (a) premises used for purposes of child minding where children are received to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days.
- (b) Persons in their areas who for reward receive into their homes children under the age of five to be looked after for the day or a substantial part thereof or for any longer period not exceeding six days.

So as to strengthen local authorities' powers certain amendments to the 1948 Act were provided in the Health Services and Public Health Act, 1968. The more significant of these amendments are as follows:—

- (a) The substitution of a period of two hours in the day (or an aggregate of two hours) in place of a substantial part of the day as the maximum period of care for which registration is required.
- (b) A provision regarding disqualification of intending organisers of child minders or pre-school play groups.
- (c) Arrangements for inspection and maintenance of the premises to a standard acceptable to the Medical Officer of Health.

Legislation regarding the provision of day care facilities for children under five has also been revised and local authorities can now obtain approval to paying child minders a small weekly sum in return for their willingness to accept children in certain priority groups placed by the authority, and in appropriate cases to paying the minder's reasonable charge. Payments can also be made for the day care of such children in nurseries or part time nursery groups run by either private or voluntary bodies. Children in the priority groups include those:—

- (a) who need temporary day care on account of the mother's illness;
- (b) whose mothers are unable to look after them adequately because they are incapable of giving young children the care they need;
- (c) for whom day care might prevent the breakdown of the mother or the break-up of the family;
- (d) whose home conditions (e.g. because of gross overcrowding) constitute a hazard to their health and welfare, and
- (e) whose health and welfare are seriously affected by a lack of opportunity for playing with others.

A pleasing aspect is that it is becoming more acceptable to the ladies responsible for organising the nurseries to admit children from deprived homes.

Although the authority does not run any day nurseries, at the end of the year there were 30 private nurseries making provision for 716 children, an increase of ten nurseries and 203 places since the end of 1967.

Medical officers and health visitors make regular routine visits to the nurseries and report on their running. Generally the latter are quite satisfactory with adequate facilities being provided for the children and competent staff. One health visitor comments as follows:—

“I have visited the play group two or three times each term. It is very popular with parents and children: in fact there is always a waiting list. As a result of activities, coffee mornings, etc., there is now a variety of tough, adventurous toys. One of the most popular until the children wore it out was an old pram without wheels. The scene is usually noisy and boisterous—there are always three ladies present and they have a quiet time in the middle of the session, reading stories while the children are given a drink”.

The following table shows the location and places available in day nurseries and child minding groups throughout the county.

Registered Nurseries

Northern Area		Southern Area		Western Area	
Alston	20	Bootle	15	Cockermouth	50
Bongtown		Distington	30	Crosby	23
C.A.D.	16	Egremont (2)	60	Portinscale	20
Bongtown Army		Frizington	20	Workington-	
Cadet Force		Millom	30	Westfield	30
Centre	20	Seascale	25	Wyndham	35
Enrith	35	Whitehaven (7)	102		
Figton	25				
Anthorn	20				
Abbeytown	20				
Drumpton	30				
Houghton	30				
Cumwhinton	30				
Aspatia	30				

Registered Child Minders

Northern Area		Southern Area	
Drumpton	20	Seascale	10

The new nurseries registered during 1968 are those at Houghton, Aspatia, Cumwhinton and Frizington. A new venture in Whitehaven caters for handicapped children during the periods when the Junior Training Centre at Hensingham is closed for holidays. It was started by the parents of children attending the Junior Training Centre and enables them to have time for shopping etc., in the knowledge that the children are being properly cared for.

Marriage Guidance Councils

The main objective of marriage guidance councils is to make contribution to the well being of society through the promotion of stable marriages and happy personal relationships. This it does by offering a wide spectrum of advice on marital problems, initially through the Marriage Guidance Counsellor who may channel specific problems to other specialists, medical, legal and spiritual. In more recent years the councils, have extended their activities to youth counselling and in co-operation with the schools, discussion groups have been arranged and accepted as a normal part of the school curriculum.

As a result of a recent meeting called by the Director of Education, a conference has been arranged in the Autumn to consider extension of youth counselling in schools. Talks are also given by the youth councillors to groups of nurses, apprentices and youth clubs.

The activities of these workers complement the work which is carried out in the schools by the health visitors and school nurses. The latter include health education on personal relationships more as an element in wider health education programmes in the schools.

Help given by the County Council takes the form of an annual grant and the provision of accommodation in Park Lane Clinic, Workington, and in Brunswick Square Clinic, Penrith, since it has now been possible for the Carlisle, Cumberland and Eden Valley Marriage Guidance Council to offer their services in the Penrith area.

The following table gives an indication of the number of cases dealt with annually since the establishment of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council in Carlisle, Workington and Penrith. The Catholic Advisory Council until recently took an active part in providing an alternative confidential counselling service for people who have problems with their marital or personal relationships. Its activities have, however, been held in abeyance since the beginning of the year.

Carlisle, Cumberland and Eden Valley Council

Year	Carlisle	Workington	Penrith	West Cumb. Couples seen in Carlisle	Catholic Advisory Council	Total
1961	49*	—	—	—	—	49*
1962	57	—	—	—	—	57
1963	55	19*	—	—	18	92*
1964	15	36	—	—	15	66
1965	39	39	—	—	3	81
1966	42	17	—	—	2	61
1967	28	14	—	—	—	42
1968	40	15*	3*	16	—	74*

* Part year only

The Secretary of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council, Mrs. E. D. Done, J.P., has been kind enough to comment on the work of the Council during the past year:—

“The work of the Marriage Guidance Council continues to make quiet progress during 1968. We had during that year six counsellors doing remedial work and seven doing educational work. Unfortunately two have now moved, one of them, Mrs. E. Wallace, did so much for the Council in West Cumberland, and we are most anxious to replace her.

We are indebted to the County Council for permitting her to work in the Park Lane Clinic, Workington, and for Mrs. Hicks' help of the Clinic in Penrith.

During 1968 our remedial Counsellors tried to help some 75 couples; 34 of these lived in the county of Cumberland, 1 in Westmorland and 40 in the city of Carlisle. They gave 200 interviews, and these clients between them had 103 children under the age of 16.

Our Education Counsellors worked very hard during this period; they held sessions in schools, youth clubs, with nurses, apprentices and young farmers clubs, both in Carlisle and through the length and breadth of the County of Cumberland. Through their work they came in contact with 1,476 young people.”

VACCINATION AND IMMUNISATION

Section 26 of the National Health Service Act, 1946

“Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox and the immunisation of such persons against diphtheria”.

VACCINATION AND IMMUNISATION

The year 1968 will be remembered mainly in this field of work for the introduction of measles vaccination. The Ministry of Health provided an approved measles vaccine to local authorities just in time for a campaign in the summer school term to vaccinate as many 4-7 year old children as possible. The months of May and June were those of maximum activity for this effort and by agreement with the family doctors the school health service undertook the vaccination of the first priority group. There was some initial anxiety about the supply of vaccine which was very restricted but when the campaign had been embarked upon it became apparent that sufficient would be available, if only, just, to protect those children who did not already have a history of suffering from measles. The situation which emerged in Cumberland was that approximately 25% of children in the infant schools received measles vaccination based on parental acceptance; and of the remainder the large majority were alleged to have had measles previously. I show below a graph of the notifications of measles in Cumberland for the past 5 years. This indicates an average of 2,000 notifications per year which is lower than would be expected from the above mentioned experience with infant school children. The wide difference can only be accounted for by some parents not calling in the doctor for measles, or the doctors themselves notifying only some of their cases. In all 2,255 children were protected in the initial campaign and as the summer and autumn progressed and vaccine became more plentiful it was possible to extend the offer of protection to younger children and to all those under 15 years who were eligible. Parents have been advised to seek measles vaccination now from their own doctor and the latter have been taking up vaccine freely from the department for this purpose. Vaccine was provided free to local authorities from the Ministry in the early stages since no financial provision had been possible by the authorities for the current financial year.

Notifications of measles have, however, continued at a rather higher level this winter (1968/69) than I had hoped in view of the vaccinations given. The following graph shows the braking effect of the vaccination programme. As part of the investigation of

the pattern of parental acceptance of measles vaccination, Dr. Hunter, Western Area Medical Officer, inquired into attitudes and actions of a group of 59 parents in his area using a questionnaire. The results of this enquiry are, I think, quite revealing. Despite the extensive publicity given to the measles vaccination scheme, 14 of the 59 parents said they did not know about it, and 29 who decided to have it done, did not in fact get around to actually having it done.

For the future, measles vaccination will be primarily a matter of protection during the second year of life—one event in the composite programme of vaccination and immunisations in childhood. As such the consistent and detailed application of this programme to each child will be a matter for the family health care team aided in a vital way by computer controlled call-up of children to the family doctor at carefully programmed intervals.

The new schedule of immunisations to which I referred in my report last year is now in use but I am a little disappointed that for various technical and staffing reasons the County Treasurer has not been able to introduce the computer controlled element to the system at the beginning of 1969 as was hoped. This should now take place about the middle of the year. I am glad to say that the general practitioners in the county have almost unanimously accepted the scheme for computer control of appointments for vaccination and immunisation.

Diphtheria Immunisation.

The numbers of children immunised during the year were as follows:—

Primary courses—pre-school children	2,883 (3095)
Primary courses—school children	530 (1130)
Reinforcing injections—pre-school children	1,847 (1841)
Reinforcing injections—school children	4,047 (4930)

The figures in brackets show the corresponding numbers for 1967. The reduction in numbers is to some extent associated with the measles vaccination campaign during the summer term and it will be very important indeed to ensure that the lost ground is recovered in 1969.

I pointed out last year that the gradual introduction of the new schedule of vaccination, which does not require a reinforcement against diphtheria and tetanus at 10 years as previously, would ultimately eliminate much of the immunisation work actually undertaken in school.

Tetanus Immunisation.

The number of children immunised in 1968 were as follows:

Primary pre-school	2,877 (3082)
Primary school children	580 (1221)
Reinforcing pre-school	1,856 (1854)
Reinforcing school children	4,166 (4927)

These figures inevitably parallel closely those relating to diphtheria immunisation since the large majority of children receive 'triple' antigen against diphtheria, tetanus, and whooping cough. The same remarks apply as to diphtheria immunisation.

Some children, however, received re-inforcement injection against tetanus from the family doctor on the occasion of minor injuries.

Whooping Cough Immunisation

During 1968, 2,849 pre-school children received primary protection against whooping cough and 1,776 received re-inforcing injection—once again a close parallel with diphtheria and tetanus protection.

Poliomyelitis Vaccination.

The figures for polio protection are shown below:

Primary pre-school children	2,845 (3215)
Primary—school children	770 (1426)
Reinforcing pre-school children	163 (106)
Reinforcing—school children	2,622 (2715)

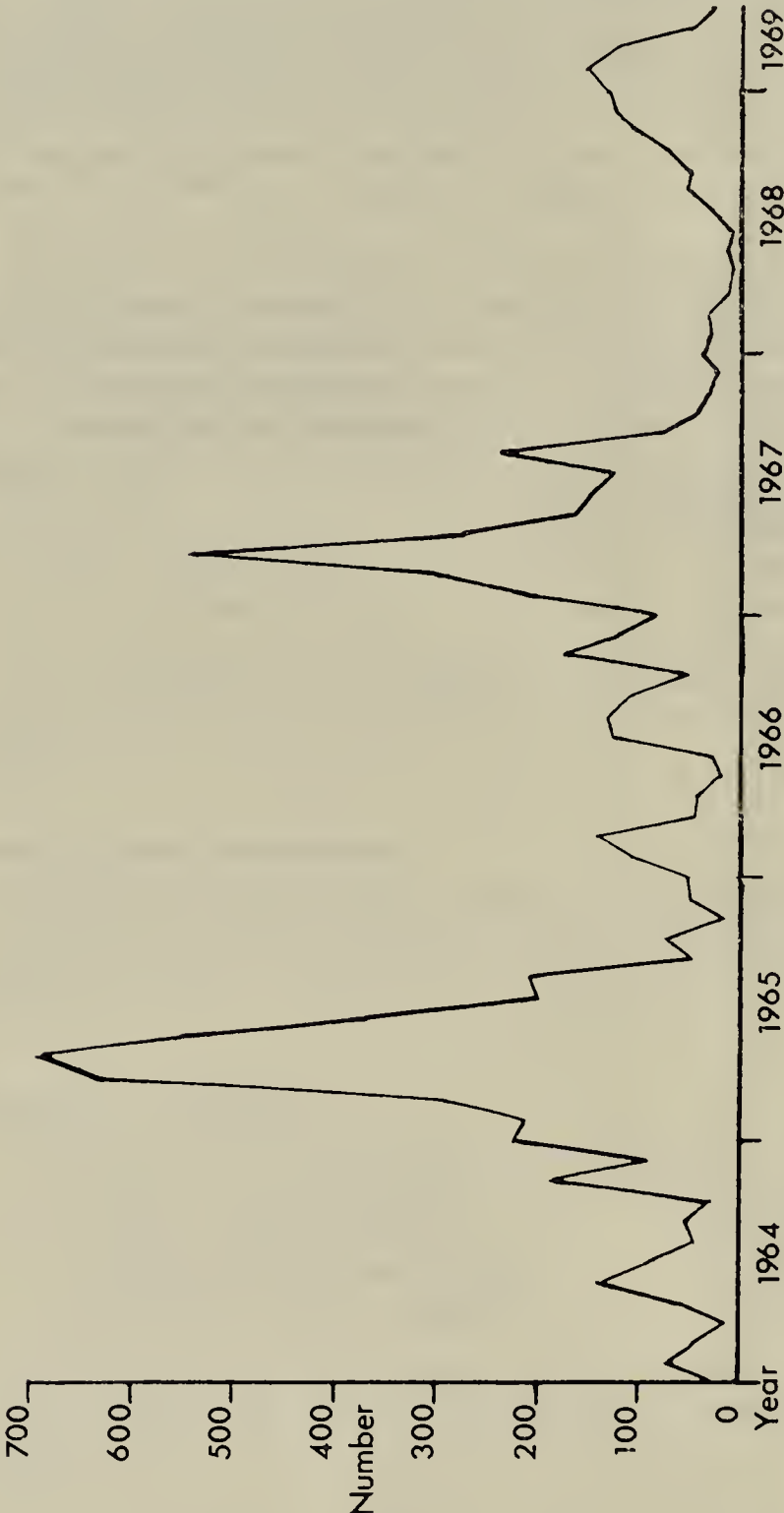
The figures for primary protection are a little lower than in 1967 and attention will be given to this also in the current year's programme.

Smallpox Vaccination.

A total of 1,726 children were vaccinated in 1968 against smallpox—still less than 50% of a full “year-group” (approx. 3,806). Although this is a fairly well sustained figure for some years now, it should be higher for adequate community as well as personal protection and I hope for significant improvement here too as the new programme gradually gets under way.

That parents continue to recognise the vital need for the maintenance of a high level of community protection against all of these diseases is of paramount importance. Such an enlightened attitude on the part of parents, coupled with the help to be given by automatic data processing machines, has the potential to produce vaccination and immunisation rates previously reckoned hardly possible.

MEASLES NOTIFICATIONS CUMBERLAND



PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946

“A local health authority may, with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purose of the prevention of illness, the care of such persons suffering from illness . . . , or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the managements.”

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

This section of the report once again brings together accounts of certain highly important local health authority services. These include cervical cytology, the provision of equipment on short term loan to patients at home, domiciliary physiotherapy, convalescent home care and chiropody. Gradually some of the topics which have in the past appeared under this heading have become absorbed into other sections of the report. One enterprise which might have been included in Section 28 is, in fact, mentioned in connection with nursing and welfare services, namely the 'screening' of elderly people on reaching their 75th birthday by a member of the group practice nursing team. Similarly health education is linked more closely in the report this year with nursing services.

Cervical Cytology

There had been a reduction in the numbers of women tested in 1967 and it was felt that in 1968 a more sustained publicity programme should be arranged to reach women who had not previously been tested. The group of women most 'at risk' are those in the lower socio-economic groups, and should be most easily reached through the general practitioner. Accordingly general practitioners were approached with a sample letter intended for women in the 'at risk' group who had not previously had a test. The form of the letter is as follows:—

Dear Madam,

Cervical Cytology

You will probably have seen reference to this subject in the daily and weekly newspapers and in the women's journals. You may be aware that it is the name given to the service provided for the early detection of cancer of the neck of the womb (or cervix).

This service has been available in Cumberland since March, 1965, and approximately 8,350 married women and widows over the age of 25 have had the test. In 46 cases further investigation has been found necessary. The test is simple and painless and makes possible the detection of cancer in its early and curable stages.

Many women have attended the clinics arranged for this purpose by the Area Medical Officer, or at my surgery, but there are many who have not had the test and who are advised to do so.

Further clinics are being arranged, which will be run by experienced nurses, or myself, who will explain the methods and undertake the test.

I trust that you will take advantage of this offer, and an appointment has been made for you as follows:—

Place:

Date:

Time:

If you then have your monthly period or are unable for any other reason to accept, please write to me or telephone the surgery asking for another appointment to be made.

Yours sincerely,

(This letter is signed by the Family Doctor)

Health visitors then commenced the task of identifying this high risk group of women in their practice. In some practices this was achieved by comparing lists of patients already known to have been tested with the age/sex register held by the practice, and in others by comparison with a list supplied by the Executive Committee indicating women in the “at risk” group for that practice.

The letter was then circulated to those selected, inviting them to attend at specific times for a cervical smear. In some instances it was found that a smear had already been taken by another organisation. In general the response was good and some 500 more smears were taken this year. Although the number taken at Local Authority clinics has decreased, this has been more than compensated for by the number taken at G.P. surgeries by Local Authority staff.

Smears taken in:—

			1967	1968
Clinic and Factory	...	...	1,270	1,014
Home	...	...	81	32
G.P. Surgeries	...	...	391	1,187
			1,742	2,233

Of some 7,000 smears examined by the pathology laboratory at the Cumberland Infirmary 2,233 were taken by Cumberland County Council staff, mostly on behalf of G.P.'s. and in their surgeries. In the case of smears taken at Local Authority clinics a safeguard against missing an initially suspicious smear is for the pathology laboratory to send a copy of the report to the appropriate G.P. and a copy to me in order to ensure follow up action. In the case of smears taken by Local Authority staff in G.P. surgeries, notification is only necessary to the G.P.

This year I was approached by the consultant pathologist for the East Cumberland Hospital Management Committee to assist in the recall of women who had had cervical smears taken at gynaecological clinics five years previously. The demand for consultations at the hospitals had precluded women being called up there for the sole purpose of taking cervical smears.

The method of recall was that lists supplied by the pathological laboratory showing name, address, age, and general practitioner at the time of the last test, were sent to area medical officers. The lists were examined and the nurses attached to the practice checked on the availability of the patient and passed on a suitably phrased letter drawing attention to the need for a repeat smear. A letter indicating the method to be used was circulated to each general practitioner stressing that in these cases the card accompanying the repeat smear should be suitably endorsed "5 year repeat".

Lists containing the names of 119 women due for a repeat smear were received from the pathological laboratory; of these a quarter have so far been re-tested; the smears have all proved negative.

This particular mass of recall is quite adequate to current needs, due to the small numbers involved, but a greater problem will present itself in 1970 when a mass recall becomes necessary or 1,715 women tested in Local Authority clinics in 1965.

Tuberculosis and Diseases of the Chest

The reports of the consultant chest physicians in East and West Cumberland which are printed as appendices to this report form as ever an important element of my Annual Report and a very significant commentary on one aspect of community health. The most striking feature of these reports in recent years has been the steady decline in the incidence of pulmonary tuberculosis and the equally steady and relentless increase in the occurrence of cancer of the lung although it will be seen that in 1968 the latter disease was a little less prominent than in the previous year this is not felt to be any indication of the long term merciless increase in lung cancer. Also it will be noticed that the occurrence of pulmonary tuberculosis may be reaching as low a level as can be expected except for very slow further progress towards eliminating this disease. The reference to bronchitis also underlines the immense and serious contribution which non-tuberculous lung disease is contributing to the overall morbidity and mortality rates in the country today. I comment elsewhere in this report on the relationship between these diseases and the smoking of cigarettes.

Once again I am greatly indebted to Dr. Hambridge and Dr. Morton for their reports and I would particularly like to pay tribute to the helpful co-operation over many years of Dr. Morton who is making his final report as senior chest physician in East Cumberland. He has always been a tower of strength to the local health authority and it is to be hoped that he enjoys a long and happy retirement.

Nursing Equipment on Short-term Loan

Under Section 28 of the National Health Act 1946 the local health authority is empowered to issue free and on temporary loan, equipment for the care and aftercare of patients in their own homes.

The larger pieces of equipment such as commodes, walking aids, crutches and mattresses are issued through the British Red Cross Society who act as agents for the health authority in return for an annual payment made by the County Council towards the cost of running each depot. There are three such depots, each one situated in one of the administrative areas of the Health Department, and collectively have issued over the past year 1,967 items of equipment of which 484 were major items.

The following table gives details of the type and quantities of nursing requisites which have been made available in 1968:—

Equipment	1964	1965	1966	1967	1968
Commodes ...	105	145	141	129	123
Crutches ...	65	62	31	31	67
Hoists Hydraulic ...	—	—	—	3	9
Hospital Beds ...	22	10	12	7	21
Invalid Chairs					
Adult type ...	134	176	167	127	129
Junior type ...	8	22	5	9	13
Mattresses					
Rubber ...	21	15	14	8	23
Inflatable ...	8	3	3	—	1
Hair ...	—	—	—	—	3
Tripod Walking Sticks	130	150	159	153	95

There has been an increase in the number of hospital beds issued on loan in 1968 and a corresponding increase in the number of rubber mattresses, crutches and invalid chairs. This indicates a move towards increasing patient care outside hospital, a trend to be encouraged, not only for economic reasons but because of the attention and care given in familiar surroundings may in itself be a useful aid to recovery.

Hoists are now being used more, to help in cases of disseminated sclerosis, paraplegia and acute arthritis.

Hoists have made it possible for patients who are rendered immobile through various physical disabilities to be cared for in the home, whereas previously hospitalisation was inevitable.

The loan equipment service sponsored by the health authority is complementary to a similar service run by the hospital authorities for patients who are discharged but still continue to receive treatment. Although local agreement has been reached to reduce the overlapping of these two services to a minimum, there is nevertheless a measure of flexibility between the service offered by the hospital service and this Health Department. In many instances the two authorities work in conjunction with one another in resolving problems. One example of this is ascertaining whether equipment on loan is still required after a reasonable length of time has expired from the time of issue. Enquiries are made by the nursing staff of this Department on behalf of the Hospital Management Committee. There has been a tendency in the past for equipment to be on loan for long periods, and difficulties have been experienced in retrieving articles of nursing equipment after the patient has recovered or had no further use of this equipment.

To alleviate this situation it was agreed that the loan equipment service should be of a temporary nature, and in the event of a patient having items of equipment on loan for three months, the patient's doctor will be notified and the patient referred to a consultant with a view to a certificate being issued and the equipment being supplied by the Department of Health and Social Security. The health authority is also prepared to issue wheelchairs and where possible self-propelled chairs for those who need them and can make use of them in the interim period while the patient is awaiting a chair through the hospital and Department of Health and Social Security.

Periodic checks are made to make sure of the whereabouts of the equipment on loan, whether it is still required and is in a serviceable condition.

The British Red Cross Society issue equipment on behalf of the County Council from three depots one of which is situated in each of the three administrative areas as follows:—

Carlisle—

2 Chatsworth Square. Monday-Friday 10.0 a.m.—12 noon

Workington—

59 Station Road. Tuesday and Thursday 10.0 a.m.—12 noon
and Friday 7.0 p.m.—8.0 p.m.

Whitehaven—

Whitehaven Hospital Tuesday and
Thursday afternoons 2.0 p.m.—4.0 p.m.

The Work of the Part-time Physiotherapist

The physiotherapy service in both the Brampton and Wigton practices has now been operating for 15 months and in the Penrith area for two months.

One day is spent in each area and is divided between the surgery and domiciliary work. More use is now being made of the surgeries which reduces travelling and allows the physiotherapist to spend more of her time in the actual treatment of patients.

During the year 70 cases have been seen in the Brampton area. Some have been treated in the hospital and followed up at home. Forty cases have been treated in the Wigton area, and in Penrith, after a slow beginning, the service is now being used to capacity.

Patients have, in the main, been cases of cerebral thrombosis with residual paralysis where the object of treatment has been to get as much recovery of function as possible, and make the patient independent; Arthritic patients, some chronic, have been given exercises and heat treatment to relieve pain and preserve mobility. Occasional splintage and the provision of walking aids have

greatly helped. Amulant cases with minor injuries, painful joints and defective breathing attend the surgeries for heat treatment, massage and exercises as requested by the doctor. The co-operation of relatives in the encouragement and supervision of exercises to some extent enables Miss Sivewright to spin out a bit more of her already limited time in the treatment of patients.

The service seems to be operating very satisfactorily and the co-operation of the doctors and nurses in the practices is invaluable.

The physiotherapy services provided by the Local Authority are on a small scale. There can, however, be no doubt that an increasing need for these has already been shown, and indeed Miss Sivewright started an extra day a week in the Penrith area at the request of the practitioners there.

Obviously there is a saving not only to the individual but to the community if patients can be treated in their homes or in their doctors' surgeries who would otherwise have to travel in some cases long distances to hospitals, and indeed perhaps in some cases need to be admitted. In an era where at long last the common sense idea of community care is very much to the forefront, there can be little doubt of the importance of the attachment of physiotherapists to community care teams. The value of these teams and the part they play in ensuring that cases do not go untreated, cannot be too highly stressed. As "field" workers they have many contacts and sources in a position to let them have details of cases requiring attention.

Convalescence

The arrangements for convalescent care for adults continues at slightly above the level of 1967, but still well below previous years as the following figures indicate:—

1964	—	83 admissions
1965	—	144 admissions
1966	—	99 admissions
1967	—	49 admissions
1968	—	55 admissions

The authority's scheme provides for a stay of a fortnight at a convalescent home for those who have passed through a trying period either of an acute illness or of an exacerbation of a more chronic condition. Because of financial circumstances some selection of cases has been necessary and this was done in close consultation with the general practitioners concerned. Consideration of the pre-disposing illness and its effect on the household as a whole were the main criteria of selection, primary selection having been directed towards referral of those who would require the minimum of medical care. All had to be ambulant and, of course, capable of deriving benefit from the facilities provided.

The convalescent home of choice has naturally been Silloth Convalescent Home, as in previous years. Only one person went elsewhere. Situated as it is on the Solway Coast (in fact nearly on the beach), in climatic conditions that are generally mild and agreeable to most cases, of easy access at any time of the year, although perhaps not so much so as before the railway closed, the Home enjoys an excellent reputation for care, comfort and consideration. It is registered as a nursing home under the Nursing Homes Act 1963, and is run on a non-profit basis under the guidance of an active management committee, of which I am a member. The Home is well staffed by matron, nurses and ancillary staff.

The selection of cases showed that a number of those recommended by general practitioners did in fact need no nursing care and probably no convalescence in the generally accepted meaning of the word. They had been put forward more because the remainder of the household would benefit from a short respite from providing constant care and attention. They were admitted to the authority's short stay and holiday home at the Towers, Skinburness, not far from Silloth Convalescent Home.

Chiropody Service

In previous years this section of my report has referred to the authority's free chiropody service for the elderly, the physically handicapped and expectant mothers but in 1968 the decision was taken that the service should no longer be provided free of charge. From 1st April, 1968, there was a charge of 2/6 per treatment. Such a step had been considered several times before but on this occasion the financial pressures were so great that this decision had to be made, very reluctantly, as an alternative to cutting this or other essential services.

Despite fears that the imposition of a charge might result in many who needed treatment not taking advantage of the service available it would seem that these fears have been unfounded. Neither has the collection of the charge caused any difficulty, although Mr. G. H. Thomas, M.Ch.S., S.R.Ch., reports:—

“One patient tried to introduce a barter system and offered me a clock in lieu of payment for her next eight visits. I confess I was sorely tempted to accept but reluctantly decided that auditors had enough problems!”

It would seem that the nett increase in patients each year has now settled down to around 5%. That was the figure in 1967 when the year closed with 5,965 patients referred for treatment and by the end of 1968 the list had grown to 6,235, an increase of just under 5%. The steadying of the rate of growth should at least make the planning and financing of the service in the future easier than when the growth was both greater and fluctuating.

The increase in each of the last two years had, in fact, been rather less than three-quarters of the increase in the number of elderly in the county.

The patients certified by their general practitioners as being in need of domiciliary treatment are 27% of the total referrals.

While the service caters for the physically handicapped and expectant mothers they account for less than one half of one per cent of the patients. The service is, for all practical purposes,

for the elderly. Mr. W. W. Gordon, M.Ch.S., S.R.Ch., S.R.N., reports:—

“The main proportion of foot defects seen were mechanical or functional such as Hallux Valgus, Hallux Rigidus, Displaced Metatarsal Phalangeal joints, hammer toes, clawing and deformities of the lesser toes. These conditions were aggravated by the almost inevitable secondary lesions of corns and callosities which cause such painful crippling immobility and incapacity in elderly patients.

The most prevalent of the nail conditions seen was the overgrown nail. Thickened nails and involuted nails were also present. There were very few cases of true ingrown nail.

It is the mechanical or functional group of patients that we see most. It is noticeable that in this group it is the secondary lesions of corns and callosities which cause the painful discomfort. An elderly person for instance can function quite adequately within his or her everyday requirements with, for example, a bunion, provided that at the same time they are not beset with corn or callosities that cripple and render them immobile. Chiropody treatment by removal of the secondary lesions and cushioning or protection of a particular area is beneficial but palliative.

Whilst it may be considered that treatment of the elderly patient is one of palliation, the means by which we can relieve the pain and discomfort of foot defects in the elderly patient should not obscure the potential for curative and preventive measures such as:—

- (a) the concept of a ‘course of treatment’ and the introduction of progressive techniques to reduce and minimise the need for repetitive visits;
- (b) advice on suitable and unsuitable footwear, even to shoe therapy—that is, facilities for altering footwear to suit a particular foot;
- (c) wider use of more permanent and corrective appliances in the management of foot defects.

Methods such as these will enable us to reduce, and in many cases prevent, the necessity of foot disabilities and alleviate the incapacities of those in need of chiropody treatment."

I am pleased to be able to report that, after an interval of over twelve months, the full-time staff of chiropodists was brought up to its establishment of six towards the end of the year. To keep the service going in the western area it meant some re-organisation of duties in the other areas so that some of their chiropodists might be available to assist, and thanks are due to the chiropodists, especially to Mrs. G. Garrett, M.Ch.S., S.R.Ch., for the additional effort which they had to put in during a prolonged difficult period. In this connection Mrs. Garrett reports:—

"Patients throughout the western area were asked to help by not making unnecessary calls on the chiropody service; new referrals were limited, and a waiting list introduced."

Also on this question of the increased case-load, with a consequent increase in the interval between treatments, Mr. G. H. Thomas reports:—

"In order to minimise the effect of this on existing patients it was reluctantly decided, in consultation with the Area Medical Officer, to introduce a waiting list for new entrants to the service.

This resulted in delays of up to six months before new patients were seen for treatment but I am convinced that it would have been wrong to have continued accepting patients for treatment in the sure knowledge that the service was not geared to cope with them.

It has been suggested that the best way to utilise the service would be to give everybody a little treatment. In this I totally disagree: the effect of spreading the benefits of the chiropody service too thinly can only result in dis-satisfaction and disenchantment with the service by the patients, those referring the patients, and those operating the service.

It is essential that the authority recognises the limitations of the service and ensures that only essential cases are treated, and that operators are utilised efficiently and given the full backing of all the facilities available to the authority."

At recent staff meetings the future of the chiropody service and the value of close co-operation with general practitioners have been mentioned and Mrs. D. E. Smart, M.I.Ch., S.R.Ch., one of two chiropodists holding sessions in clinics which are also used as their surgeries by genral practitioners, reports:—

"With the new arrangement of the medical practitioner holding his surgery in the Cleator Moor clinic the co-operation between the chiropodist, the doctor, and the health visitor and nurses attached to the practice is excellent. I personally feel this goes to prove that working together as a unit in the health centre is the solution to a better and more satisfactory service."

Mrs. Garrett says she

"Would like to see improved communications between the orthopaedic and diabetic clinics and the chiropody service, and would particularly appreciate being informed about the progress of chiropody patients referred to those clinics."

On the future of the service, Mrs. J. E. Glaister, M.Ch.S., S.R.Ch., considers that

"Chiropody within the School Health Service is essential if a serious attempt is to be made to curb the rise of foot disorders in the young. Children's feet should be examined regularly, and parents should be encouraged to bring their children for examination and any treatment which may be found necessary. There is a great need for education of both parents and children to prevent conditions arising in later life."

In addition to the six full-time chiropodists the authority has arrangements with thirteen chiropodists in private practice for them to see patients under the county scheme in their own surgeries.

at the patients' own homes or to undertake clinic work on a sessional basis. 13,574 treatments were given by the full-time staff during the course of the year compared with 13,991 treatments by the part-time staff, who in total are equivalent to about five working full time. At present there is a limit of 350 patients under the county scheme for any one part-time chiropodist but at the end of the year the authority proposed to review this number and possibly to reduce it. The establishment of full-time officers will, of course, be increased so that the cases relinquished by the part-time chiropodists can be taken over in furtherance of the authority's policy to have eventually a full time service wherever possible.

The possibility of making more appliances has been under investigation and Mr. Thomas writes:—

“On the appliance side of the service I have recently been carrying out insole work using an expanded polythylene material. Initial results are very encouraging, it being possible to obtain extremely accurate moulded impressions for built-up inner soles. It is as yet a little early to fully assess how this material will compare with other conventional materials with regard to wear but at approximately half the cost it would appear to be a sound economy. Unfortunately, owing to the lack of specialised equipment, it has not been possible to explore the full potential of this material which I feel offers very exciting possibilities.

An advancement in the use of silicone rubber in chiropody since my last report has been the introduction of a preparation which enables the chiropodist to carry in one small tube all that is necessary to make, for example, moulded replaceable toe appliances without impressions or costing ready to wear in a matter of 30 minutes, at the chair-side or in the patients' home without inconvenience or elaborate equipment.

This same material can also be used as a nail packing and as a ‘filling’ following the enucleation of corns with most beneficial results.”

These interesting developments in technique along with the trends mentioned above towards a more stable number of elderly patients cared for by more full-time chiropodists, represents the settling down administratively of this important service; and at the same time its advance in methods and efficiency.

Venereal Diseases

The following is an extract from the report of Dr. H. J. Bell, Consultant Venereologist:—

“For some years now the following Table has had a place in my Report:—

Year		Early V.D. Infections		Total attendances	
		Carlisle	Whitehaven	Carlisle	Whitehaven
1957	...	45	17	741	363
1958	...	45	22	806	301
1959	...	69	20	893	398
1960	...	74	20	920	472
1961	...	67	20	755	454
1962	...	70	52	640	473
1963	...	86	41	715	266
1964	...	84	56	635	284
1965	...	99	68	730	388
1966	...	79	61	742	443
1967	...	108	94	776	389
1968	...	109	92	833	251

Under the label ‘Early V.D. Infections’ I include cases of syphilis in the first three years of infection, acute gonorrhoea, and all cases of non-specific urethritis (exclusively a male condition) although the Department of Health and Social Security is not yet prepared to list non-specific urethritis (N.S.U.) as a form of venereal disease.

As for the early V.D. Infections, they show no tendency to decline in our area. Gonorrhoea, of course, presents the novel difficulty that, as far as women are concerned, the infection is usually a ‘silent’ one and the patient afflicted sees nothing and feels nothing to alert her that she should seek medical aid. Because of this outstanding difficulty—and there are many others—gonorrhoea is likely to remain uncontrollable by any measures, therapeutic, epidemiological or sociological. Likewise, the urethral discharge in males which we call non-specific urethritis (N.S.U.) is likely to remain outside medical control for similar reasons. Syphilis, fortunately, is still a condition without real menace in the United Kingdom.

It has to be admitted that the modern menace of Venereal Disease is almost entirely concerned with gonorrhoea. As far as the Carlisle Clinic is concerned the increase during the last seventeen years in cases of this disease has been progressive. The England and Wales graph reveals a 'plateau' around the 15—16,000 mark from 1952 to 1955, followed by a sharp uplift over the period until 1961 (with a two-fold increase). Then follows an undulating plateau until 1968, when the total figure was more than 44,000. This is worse than the figure of forty years ago."

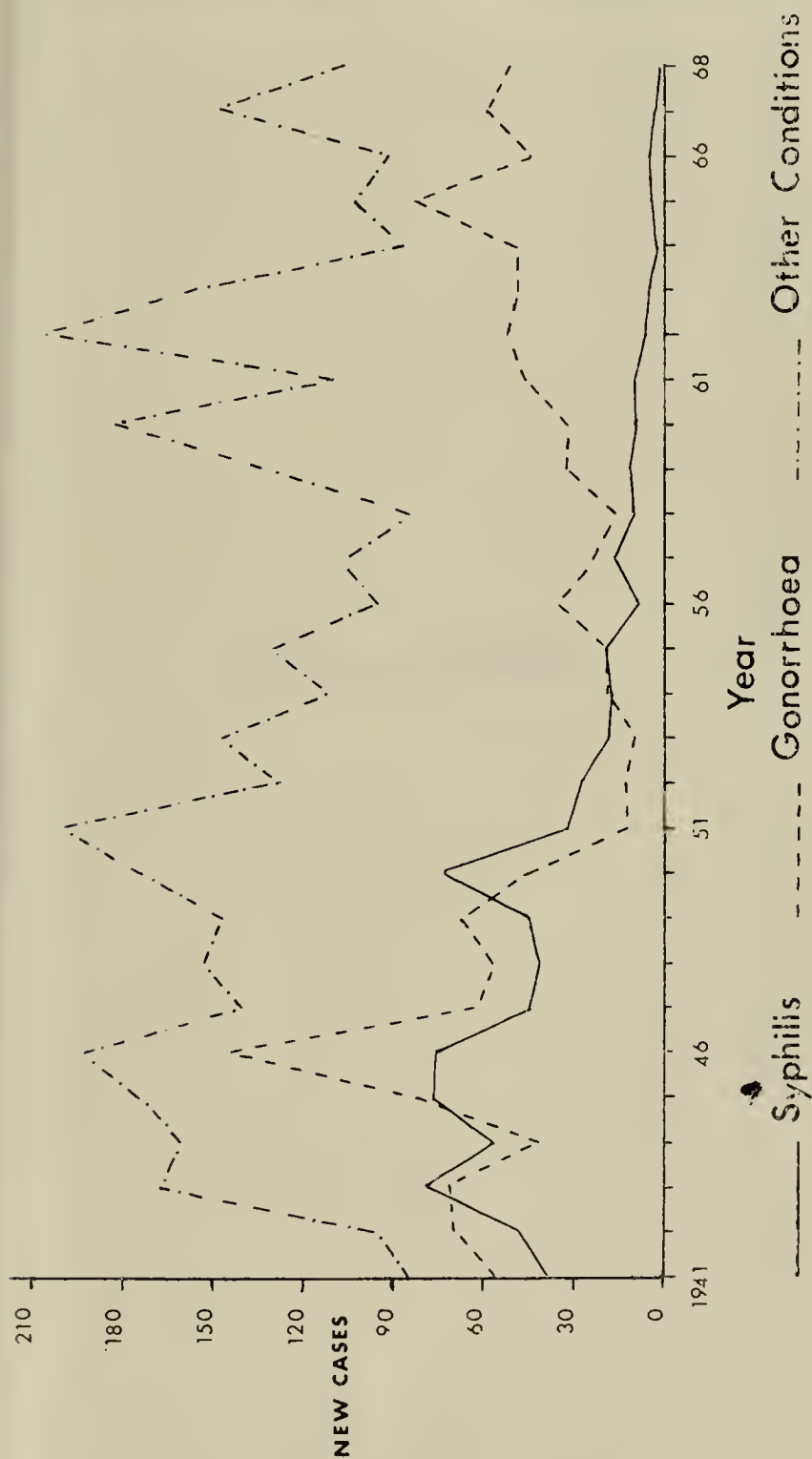
The graph on page — shows the new cases of venereal disease in Cumberland from 1941-1968. This represents only cases whose normal place of residence is in the administrative county of Cumberland and therefore gives a more specific picture of the administrative county. The figures quoted by Dr. Bell above refer to clinics at which the persons attended whose home is not in Cumberland i.e. either in neighbouring authorities or more distant parts attending his clinics. It will be seen that there has been a significant rise in the cases of gonorrhoea since the early 1950s.

The most effective means of control over the spread of this communicable disease is to make the public aware of the essential facts, and thereafter to promote the tracing of sources of infection, mostly contacts. This is, of course, made more difficult by the tendency of some infected members of the public to conceal the fact that they have been in contact with the disease.

It is essential, therefore, that an efficient organisation exists to cope with contact tracing and in Cumberland we have an arrangement whereby any requests made by the Consultant Venereologist are taken up by appropriate local authority staff (health visitor, social welfare officers, etc.). This has proved a satisfactory arrangement to all concerned.

In the western area of the county some contact tracing has been undertaken by a Health Visitor who deals with an average of 6 requests per year, and by a male nurse, who does occasional contact tracing of male patients.

VENEREAL DISEASES—NEW CASES PER YEAR
1941 to 1968
ADMINISTRATIVE COUNTY OF CUMBERLAND



WELFARE SERVICES

WELFARE SERVICES

The development of the local authority's welfare services during recent years has been directed towards the re-orientation of services and the redeployment of resources so that increasing demands in constantly changing social situations could be met more effectively. This has necessitated a continuing process of assessment and re-appraisal of need with consequential adjustments in the manner in which scarce resources (both in manpower and finance) could be utilised to best advantage. Extensions, variations or modifications of specific welfare services, however, have only been implemented in conformity with the broad principles which have emerged in this combined Health and Welfare Department (a) that the local authority's community services should be unified through family health care teams of health visitor, district nurse and social worker, operating in direct attachment to, and under the overall leadership of, the family doctor and (b) that this team-work approach in the home situation must be coupled with firm liaison and co-operation with the hospital services at all levels.

It is in the concept that all branches of the National Health Service are interdependent on each other that local authority services have been integrated with the hospital and general practitioners' services as far as is possible within the existing structures to achieve a full spectrum of care and support for the elderly and those handicapped by physical or mental disability. The long-awaited report of the Committee on Local Authority and Allied Personal Social Services (the Seebohm Report) was published during the year and, whilst accepting what has been described as the "inexorable logic" of the Committee's central proposal for the establishment of unified social service department, an element of fragmentation to set against the integration of the social services envisaged in the report arises from the Seebohm proposals which would lead to the separation of health and welfare services which, in many places, including Cumberland, are at present integrated.

On the basis of local experience I have serious misgivings about the desirability of attempting to separate medical from social needs. This issue itself presents an enormous task of re-organisation of the personal social services which, when the shape of the new structure is determined, will require a progressive re-orientation of approach to medico-social problems. The Seebohm recommendations cannot in my opinion be considered in isolation at a time when the administrative structure of the National Health Service (including the local health authority's functions) is also under review. The Royal Commission on Local Government may not have as much direct effect on the revised structure of the medical and social services which will ultimately emerge, but administrative re-organisation usually involves professional re-organisation. One can only hope that whatever changes are foreshadowed will be implemented in such a manner that continuity of service to the community we serve is ensured during the process.

Residential Accommodation

(a) For the Elderly

At the end of the year 432 beds were provided in Welfare Homes for those elderly "in need of care and attention which is not otherwise available to them". The three main categories into which this form of provision can be divided are as follows:—

	Number	Beds provided
Joint-user establishments	1	60
Adapted premises	5	113
Purpose-designed homes	9	259
	15	432

The policy, both nationally and locally, is to provide supportive services where these are indicated in relation to the elderly from statutory and voluntary sources which will allow them to continue to live in their own homes. If it is impossible or impracticable to provide the degree of support which is necessary in the home situation, the alternative of residential care in a Welfare Home must be considered and a statutory obligation rests with the welfare authority to make adequate accommodation in residential Homes available. The population of the administrative county is distributed in relatively small pockets over a wide geographical area and for this reason the policy has been for providing relatively small units built to modern standards of comfort and amenity on a "neighbourhood basis", so that on admission to residential care the old persons remain close to relatives, friends and the community in which they have been living. Running alongside this policy has been the determination of the Council to close down the remaining former Public Assistance Institutions which latterly have been joint-user establishments with the hospital authorities. The following table shows the manner in which this policy has been implemented to date:—

At December	Joint-user establishments	Number of beds provided		Total
		Adapted premises	Purpose-built Homes	
1952	325	—	—	325
1953	325	19	—	344
1954	325	19	—	344
1955	263	69	—	332
1956	263	69	—	332
1957	242	69	—	311
1958	242	113	—	357
1959	252	113	—	365
1960	215	113	38	366
1961	215	113	38	366
1962	117	113	114	344
1963	117	113	114	344
1964	117	113	114	344
1965	117	113	149	379
1966	117	113	189	419
1967	115	113	199	427
1968	60	113	259	432

Looking at these figures from a negative viewpoint it is apparent that the number of beds available in Welfare Homes for the elderly has only increased from 365 to 432 (rather less than 18 per cent) in the space of ten years. When viewed from a broader aspect one sees this progress more in terms of the closure of two former workhouses which, in spite of determined effort and continuing expense to achieve upgrading of the environment, inevitably retain some aura of the poverty and degradation with which they were associated in the nineteenth century. To some extent, therefore, the pattern of development during the past ten years has been largely a replacement programme during which nine purpose designed Welfare Homes, ranging in size from ten to forty beds have (a) taken the place of two former Public Assistance Institutions and (b) have provided accommodation designed to standards of amenity and comfort which are acceptable to present day concepts in seven additional centres of population in the county area.

The programme for the development of welfare accommodation, in common with other enterprises requiring capital expenditure, has been delayed because of the national economic situation, and the authority's proposals for the opening of further welfare Homes to meet the ascertained need has been drastically

curtailed. In the early part of the year, local authorities were asked to review their capital development programmes for the years 1968/69, 1969/70, 1970/71, in the light of the financial situation and in compliance with this request a revised programme was drawn up taking account of changed local circumstances and need. After very careful consideration the conclusion was reached that it would not be possible in the next few years to open more than one additional Home each year because of the restriction to 3 per cent gross increase per annum in revenue expenditure.

The capital development programme may now briefly be summarised as follows—a new Home at Millom providing 25 beds in association with a small supported independency scheme is under construction, and is expected to be handed over by the builders about June, 1969. The Wigton Home (40 beds) to replace the last of the joint-user establishments at Highfield House is partly built and should be taken over from the contractors about July, 1969. Building operations have just begun on the Keswick Home (25 beds) which was originally scheduled in the 1967/68 programme, but deferred for financial reasons to the following year. A second Home at Workington (Westfield), 40 beds, which was originally programmed for 1968/69, has now been approved by the Ministry for inclusion in the 1969/70 programme. An additional Home to serve the Whitehaven area to be located at Mirehouse and accommodating 40 residents, has been accepted for inclusion in the 1970/71 programme after a year's deferment. Of all these developments only the Wigton Home can be regarded as a replacement so that a progressive increase in the total number of beds available in Welfare Homes can now be expected, although this stage in forward planning to meet need which is known to exist has been reached at a much later stage than the Council approved or would have wished.

The frustrations surrounding this situation, however, were temporarily mollified during the year in seeing the fruition of earlier plans by the opening of three new residential establishments—two for the elderly and one for the physically handicapped. A new purpose-built Home for 40 residents and named "Greengarth" was opened in May to replace the Part III accommodation at Station View House, Penrith. Station View House was built in 1838, and after the transfer of the Part III residents from this

former Public Assistance Institution to modern premises it was necessary for the patients in the hospital section of the joint-user establishment to remain until they could be accommodated in the new Penrith Hospital. The forward planning of the administrative implications behind this move were complicated by the fact that many of the domestic services such as heating and catering were shared on an apportionment basis between the two users— the local authority and the Hospital Management Committee. With a noteworthy spirit of co-operation between the officers, and by careful attention to detail, these administrative difficulties were resolved to the satisfaction of both parties, so that the hospital service could continue to function with a minimum of disruption after the departure of the local authority's residents and staff to their new Home. Many of the residents at Station View House had been living there for a number of years, and it was thought important to make preparations in very great detail for the actual move so that when the time came it could take place smoothly, efficiently and with as little emotional upset as possible. These arrangements were drawn up by my administrative staff, the matron and social workers, and were circulated and understood by anyone who had any part to play in the transfer. I am quite convinced that the time spent in preparation for the move, and in drawing up the schedule of operations was time very well spent indeed. For instance, all the residents except the very infirm were taken down to "Greengarth" to be shown their own bedroom, to be made familiar with the geography of the place, and in particular the location of dining room, lounges, toilets and bathrooms, and to have instruction and practice in the operation of the lift. This part of the exercise was obviously very time consuming and would not have been possible without the enormous help which came from voluntary sources. Moving house for even a small family can prove to be a traumatic experience, and when 40 very old people most of whom tend to be suspicious or apprehensive about change in any form, are involved, the effect could reach enormous proportions. I am, therefore, most grateful to all the members of my staff and all the voluntary workers, whose efforts resulted in a very smooth and efficient operation. I look forward to a repeat performance in 1969 when the last of the former Public Assistance Institutions at Highfield House, Wigton, is closed.

A new Home (Eskdale House) was opened at Longtown in June to accommodate 20 elderly in 16 single bedrooms and 2 double bedrooms, which are easily convertible to single units. This unit, together with the one last mentioned at Penrith, provide only 5 more beds than were available at the former Public Assistance Institution, but the opening of a Home at Longtown makes it possible to offer welfare accommodation on a "neighbourhood" basis to the residents of that area who before its opening would have had to move away from the district if they were in need of residential care.

I think it is generally agreed that waiting lists for welfare accommodation are not reliable yard-sticks by which to measure the need for residential care. Such lists, must, however, be kept and for record purposes it should be noted that at its lowest the number of those waiting admission during the year numbered 99, the highest figure being 130, the average being 111. Some of these were occupying hospital beds whilst waiting transfer to welfare homes. The highest number recorded in this category at any one time being 20 and the lowest 5—the average being nearly 13.

The pattern of joint consultative machinery envisaged in the 1965 memorandum on "The Care of the Elderly in Hospital and Homes" is now firmly established in this area and in practice has resulted in close and regular consultation and co-operation at all levels between the local authority and hospital services for the elderly. Because of the understanding of the problems of the elderly as they affect the two services and as a result of the liaison which has emerged, there is increasing mobility between the hospitals and welfare homes. In spite of material inadequacies personal consultation between doctors, nurses and social workers in the hospital and local authority fields results in difficulties being overcome because there is a mutual determination to consider the needs of the individual as of paramount importance. The willingness to regard hospital assessment and treatment units, long stay geriatric wards and the accommodation in welfare homes and special housing as a continuum of services for the elderly is illustrated by the fact that during 1968 almost exactly half of the admissions to welfare homes (68 out of 134) came from hos-

pitals and that during the same period 155 residents of Part III accommodation were admitted to hospital, of whom 70 were able to return to welfare homes after treatment. Linking with this hospital/welfare home situation are the supportive services of the general practitioner and their family health care teams and easy channels of communication between all three arms of the National Health Service are opened up by the attachment of nursing (and in some cases social work) services to the family doctor groups so that services to the elderly can be brought into play quickly and in a fully co-ordinated manner.

It becomes increasingly necessary to ensure that as vacancies occur in welfare homes the beds are offered to those in greatest need and to achieve this the aim is towards a positive pattern of planned assessment. Many people may be involved or have relevant information to contribute to this composite form of psycho-social-geriatric assessment. In association with the consultants in geriatric medicine and psychiatry, the general practitioners and my own medical, nursing and social work staffs, procedures are being evolved which will ensure that accurate up to date information relating to all aspects of the problem is available and collated in a simple fashion so that by accurate appraisal of the total situation the need can be identified and its degree of urgency more clearly defined.

In previous reports I have commented on the increasing infirmity of our residents in welfare homes which presents problems of organisation and staffing levels within the homes and requires continual revision of design standards. This trend towards greater degrees of physical and mental handicapped in our residents shows no sign of easing and is to be expected when it is borne in mind that the **average** age on admission during 1968 was 78 years.

The problems created by the fact that there is a waiting list for admission to residential accommodation for the elderly, are many and difficult. I can best explain some of these by quoting the circumstances which led to the admission of one old gentleman and the problems surrounding two ladies still waiting for a vacancy in a Home.

Mr. X aged 66 years lived with his son. His circumstances were reported to the senior social worker for the area by the Probation Department, when the son who was on probation left the area. When visited it was apparent that Mr. X was a demented, rather isolated, withdrawn, individual who lived his spartan existence in rather pitiful surroundings. Initially he refused all offers of help, but after patient visiting he agreed to the provision of a home help and meals-on-wheels. He would not, however, entertain the idea of having a coal fire in the house and satisfactory heating was only achieved after the local Housing Department had been approached regarding the installation of additional power points and the purchase of two electric fires.

Despite supportive services Mr. X continued to deteriorate. The matter was referred to the consultant psychiatrist and admission was arranged to the psychiatric unit of the district general hospital. In addition to his dementia, examination revealed that he suffered from bronchitis, left ventricular failure and auricular fibrillation. After treatment he became more mobile, but it was felt that he would never be able to return to his home and hence he was transferred to a geriatric unit, and from there was admitted to a Home in his town of origin.

Mrs. Y aged 76 years has lived alone for 8 years. She has a son living in the area. She had a slight stroke in January, 1968 and received hospital treatment. After being placed on the waiting list for admission to Greengarth (the only Home in the area) she was discharged to her own home with the services of a home help, health visitor, home nurse and meals on wheels. There has since been a gradual deterioration in her health and she now has frequent falls about the house. She has refused the offer of a vacancy in a Home in another part of the county pending a vacancy in Greengarth.

Mrs. Z a 79 year old widow has lived alone in her well appointed bungalow for 8 years since the death of her husband. She was found on the floor one morning having suffered a heart attack. After medical treatment at home she left the area a few days later to reside with a married daughter. Whilst there she was admitted to hospital following another attack. She was

discharged to her daughter's home with some residual left sided weakness. Following friction with her daughter she decided to return to her own home in spite of the fact that she knew that she would be unable to cook for herself and do the housework, etc. She was also very apprehensive at being on her own at night. A home help was put in to clean the home and prepare the mid-day meal since the meals on wheels service does not cover this particular area. The district nurse visits regularly, as does the social welfare officer. Mrs. Z refuses the offer of day centre care. She has been registered as handicapped and provided with walking aids and special cutlery. She still awaits admission to a Home.

The aim to retain the elderly in their own homes by providing supportive domiciliary services—as a result of which more than 97% continue at home—obviously makes enormous and increasing demands upon these services as is illustrated in the figures quoted below:—

Service	Number of elderly served during 1968	Percentage increase of number served during 1968	Number served as a percentage of of population aged 65 years and over
Chiropody	6,410*	11.5	23.3
Health Visitor	3,566	12.0	13.0
Home Nursing	4,153	15.0	15.0
Home Help	1,132	6.5	4.1

*This figure differs from that shown on page 143 and is accounted for by deaths during the year."

Day centres, luncheon clubs and meals on wheels make a very significant contribution in this context—details of which appear later in this report.

(b) For the Physically Handicapped

Another milestone has been reached by the opening of Alneburgh House at Maryport which admitted its first residents on the 24th June, 1968. This is one of the very few purpose-designed units to cater for those younger physically handicapped adults who need a degree of care and attention which cannot adequately be met in the home situation.

Alneburgh House aims to provide a complete environment in which the residents can live as independent, active and varied a life as their disabilities allow. There was little experience of this type of provision on which to draw, so that much thought went into its planning and every possible source of information and advice was carefully explored. Each of the 20 residents has his own room which is equipped as a "bed-sitter" to encourage independence and the expression of personality, and to allow complete privacy when required. A workshop is provided within the Home at which regular attendance is encouraged but not enforced, and where industrial outwork is undertaken. Diversional therapy which includes creative activities is provided through a part-time therapist. The area of main activity within the Home after working hours is a spacious sitting/dining area which on an open plan basis has proved very suitable for a wide range of communal activities ranging from film shows to "pop sessions" and parties of all kinds.

All those concerned in the establishment of this Home have been greatly encouraged by the support given by the local residents, and in particular by the youth organisations in the town. Their continuing enthusiasm has been invaluable in helping to create a happy and active atmosphere within the Home; in introducing the residents to a variety of social, sporting and cultural activities outside the Home, with the result that the lives of many of the residents have been transformed by the creation of interests previously unknown to them; and by demonstrating, not merely the concept of "community care", but that the community really cares about them.

The build-up in the number of residents at Alneburgh House was deliberately slow because of the supreme importance which was attached to careful selection. In broad principle, the Council's aims in providing this unit were to cater for those younger people in the community suffering from severe disabling conditions, and at the same time present the opportunity for some of those who have been maintained at the authority's expense in specialised accommodation outside the county to return to Cumberland. An Advisory Committee was constituted to consider applications for admission. In addition to medical, administrative, social work

and nursing representatives from my department. I am pleased that Dr. Kaminski of the West Cumberland Hospital, agreed to join the Committee until such time as the consultant in physical medicine takes up his appointment, and that a representative of the large group practice in the town (Dr. Rattrie) was able to accept nomination to the Advisory Committee. Present indications are that the best use of this unit will be to provide residential care on a long term basis for younger people suffering from severe (and frequently progressive) physical conditions, and with this type of resident the turnover will be very small indeed. In consequence it is considered necessary to reserve a small proportion of the total accommodation for those who will probably only require the facilities which the Home can offer for a limited period—to offer a holiday from their own home to those handicapped who require special domestic facilities to cope with their disability, to give relief to relatives so that they may have a break from the continual strain of caring for a severely disabled person, and to be able to meet unexpected domestic crises which involve a grossly handicapped person as they arise.

The following table summarises the admissions which had taken place to the year end:—

	Long term		Temporary		Total	
From:—	M	F	M	F	M	F
Home	7	3	2	—	9	3
Other Local Authority or Voluntary Homes	4	—	1	1	5	1
	11	3	3	1	14	4

All those admitted for short-term care were discharged before the end of the year after stays ranging from 12 to 34 days—the average being 18 days. On the 31st December, 1968, therefore, there were 11 men and 3 women regarded as long-term residents (although three of these were, in fact, still celebrating the festive season in their own homes). Ages, sex and diagnoses are as follows:—

	Male	Female
Spastic quadriplegia	2 (16 & 20 years)	2 (19 & 20 years)
Hemiplegia	2 (20 & 54 years)	1 (48 years)
Paraplegia	2 (19 & 37 years)	
Friedreich's ataxia	2 (31 & 27 years)	
Progressive muscular atrophy	1 (45 years)	
Syringomyelia	1 (30 years)	
Familial cerebellar ataxia	1 (18 years)	

From this it will be noted that the average age is 29 years.

Mr. W. L. Anderson (Matron) reports as follows:—

“The age range of our small family is 16 to 54 years, with three females and thirteen males making up the total. Having such an age variation presents a tremendous variety of needs and attitudes, but the following principles from a standard text book can be applied:—

- (a) The problems of every handicapped person are highly individual and personal.
- (b) The best solution for any handicapped person is that one which is as near normal as possible.
- (c) A large amount of improvisation will be necessary.
- (d) Great determination and singleness of purpose is essential for success.

To these I would add that in order to advise or assist a handicapped person within a residential setting, the starting point for the formulation of a policy is based on the assumption that we are a complete family unit, i.e. to approach a problem as one would smooth out a difficulty in one's own family, assessing individual needs both physical and spiritual.

By applying the above principles, Alneburgh House has had a comparatively good staff-resident relationship. Frictions may occur but provided a complete trust exists between senior staff and residents major pitfalls and serious clashes of personalities

can be avoided. To foster good relations, no fixed code of do's and don'ts have been necessary, with the exception of prompt attendance at meals and working hours. It has only been necessary to establish the principle of 'consideration of others' as a working base line and the encouragement of self-discipline to iron out problems of inter-resident relationships.

A great asset to the application of self-discipline has been the establishment of a Residents' Committee. All residents, with two exceptions, participate and they are encouraged to comment and offer suggestions for improving day to day routine. The activities of the Committee are gradually widening, more emphasis I feel being placed on self-discipline, but care must be exercised to ensure that the most dominant character does not emerge as 'king pin' and assume a dictatorial position. By applying the foregoing principles in their broadest sense, only on three occasions have I had to reprimand formally an individual for unacceptable behaviour. I trust that in the future discipline will as easily be maintained.

Workshop Activities

Activities within the workroom have been regulated to provide the residents with an occupation and a sense of fulfilment and purpose, which is essential to their well-being. Basically the working day is from 9.30 a.m. to 12 mid-day and 2 p.m. to 4.30 p.m. For a two session attendance a payment of 2/- is made to each resident, payment being on a monthly basis, and in the future it is hoped that a system of incentive bonuses will be awarded for initiative and drive rather than overall production ability.

To finance our 'wages bill' work has to be found from a remunerative source, and for this we looked to our local industry. With the co-operation of local factories, the workroom has now undertaken two types of work.

We have one long-term contract to assemble car battery plastic plugs. A side issue of this work was the offer of assistance by the design engineer of another company to develop and make a machine to mechanise the manual assembly of the battery plugs. To date we have tested the prototype and hope to have mechanised our team and therefore increased our productive potential in the next few months.

A seasonal contract was undertaken last autumn by participation in the international advertising campaign of a local clothing manufacturing company. The part we played was to receive the postal requests for brochures, prepare and type a brochure for despatch, code the source of enquiry as to origin, and assess the geographical demand for the brochure. All this information was necessary so that the retail outlets throughout the country could estimate what the demand would be for fashions during the forthcoming season.

Unfortunately, contract work can fluctuate, therefore during a slack period attempts were made to initiate an industrial craft in which the more creative and able residents could participate. To concentrate solely on repetitive assembly processes, which can be demoralising to the more able individuals, leads to a state of mental stagnation and complete rejection of our community spirit that we are striving to foster. The selected craft material was Honister Green Slate. With help and advice work has been undertaken by a selected number of residents.

Originality is the basic aim, with a reasonable financial return. Lamps, book-ends, pen-stands and lamp/book-racks have been produced in this attractive material and work is now being carried out for the first order for retail outlet for the forthcoming tourist season. As an industrial craft the scope of design and quality could be improved by more sophisticated equipment, but this will be overcome in the long term.

An off-shoot of the workroom regime is further educational studies. If necessary part of the working day is allocated to participating individuals for private study. At the moment one young lady is studying with a voluntary private tutor to sit the G.C.E. 'O' level examination in English Literature. A second tutor is being arranged to tutor a young man to G.C.E. level in English Language and Mathematics. Evening classes are being followed by another two residents in oil painting, sketching and basic English.

Although rehabilitation is not one of our primary functions, this aspect cannot be ignored and is given every consideration. No pinnacle is out of reach for the physically disabled. This point

has been ably demonstrated by one of our residents who, after three months stay, was able to undertake a full-time clerical post of some considerable responsibility.

The social integration with the local community has been extremely smooth and rapid. Over a period of time individuals, some motivated by the highest principles, others by curiosity and pity (one frank young lad stated he had nowhere to go one wet evening so he opened the door and came in), have been a constant source of support and encouragement. The relationship of residents to visitors was initially casual and generalised, but gradually personal ties could be seen to be emerging until firm family relationships with residents have been established. In fact most of the residents have regular social contact with family groups.

One particular aspect of social contact has been the massive response and support from the youth of the community, particularly the members of ALL Souls Youth Club. The members of the club, together with teenagers in no way connected with an organisation, have given the residents continuous support in all aspects of community living, ranging from personal contact and friendship, escorting them out for a multitude of reasons, Sunday Church service, visiting the local library, dance hall, cinema, youth club, the 'local' for an occasional drink, and attending folk music concerts in Carlisle, week-end shopping in Whitehaven, Workington or Carlisle.

Particularly important is the constant stream of regular visitors who turn up each evening commencing at about 5.30 p.m. The first ones are usually the individuals at school, 13-14 year olds; the working ones arrive about seven o'clock. If a person is on shift work very often they can be seen here in the morning, before going to work.

An important factor is that the youths who visit do not only offer friendship but practical down to earth help. If there is a period of staff shortage the youngsters arrive prepared to work and have in the past tackled jobs ranging from scrubbing the kitchen floor or toilets to writing letters for an individual. What one must admire is the continuous lasting efforts of the youth of Maryport.

A resident writes:—

“A great deal is said about the waywardness and thoughtlessness of the youth of today. Since Alneburgh House opened in May 1968 the young folk in the area have reacted with an enthusiasm and vigour which belies all the usual ‘clap trap’. Apart from helping practically in the home, they help to facilitate easy integration in the community at large. Their company helps to keep the residents alert socially, and the home cheerful and alive.”

Owing to the support offered by the youth of the community, ambitious schemes have been attempted with success. Within our first six months a fund had been opened for the purchase of custom-built transport that can accommodate wheelchairs and our special needs. A sponsored walk, carnival and sports day, charity concerts, were all organised to finance our ‘bus’. To date the balance is £700, and further schemes are afoot for the spring and summer.

Of course life should not be all ‘take’ and we reciprocate by offering hospitality, arranging fancy dress ‘dances’ for the residents and their friends, inviting pop groups, and one evening entertained the residents from the old people’s homes in Maryport, Workington and Cockermouth. The offer of hospitality to the residents of other Homes is a positive social responsibility that the residents will eventually shoulder.

At one time or another, in 1968 practically every organised youth group in Maryport has been involved or had contact with Alneburgh House. Individuals ranging from school children, university students, long haired psychedelic characters, a shy pre-nursing cadet, mature family groups with a great depth of understanding, to ‘head in the clouds’ intellectuals—each and everyone have contributed something that makes life for the residents of Alneburgh House worth living.

(c) Out-county provision

Arrangements for the residential care of persons normally resident within its area can be made with other local authorities or voluntary agencies. At the end of 1968, the following Cumberland residents were so accommodated:—

Local Authority Homes	Male	Female
Louth, Lincolnshire	1	—
Steeton, West Riding	—	1
Staveley, Westmorland	1	—
Hoyle, Cheshire	1	—
Stannington, Northumberland	—	1
Elizabeth Welsh House, Carlisle	1	—
	—	—
	4	2
	—	—

Voluntary Homes

Ernest Aycliffe Home for the Deaf, Leeds	1	—
David Lewis Epileptic Colony, Cheshire	1	—
Scalesceugh Home for Spastics, Carlisle	2	1
Cheshire Home, Windermere	—	1
Eothen Homes, Whitley Bay	—	1
Methodist Home for the Aged, Liverpool	1	1
Church of Scotland Home, Greenbank, Langholm	—	1
Maghull Homes, Nr. Liverpool	1	—
British Legion Home, Ripon, Yorkshire	1	—
Auchinlee Eventide Home, Campbeltown, Argyll	—	1
	—	—
	7	6
	—	—

Staffing and Training

(a) Social Workers:—

It is now 10 years since the Council accepted the principle of secondment to approved courses of training as a means of ensuring, in the long term, that adequately trained field workers would be available in sufficient numbers to meet ever increasing demands for their services. The benefits accruing from these schemes seem painfully slow in coming to maturity and indeed there were times when doubts were beginning to be felt as to the wisdom of the policy. These doubts arose from the fact that Cumberland was making a generous contribution to the general pool of training in the expectation that officers trained at the Council's expense would in due course move elsewhere to widen their experience but equally it was expected that adequately trained staff would be available and that some would seek appointments with this authority. In the absence of any "pooling" arrangements many authorities were unwilling to involve themselves in the cost of training procedures. In this unbalanced situation Cumberland tended to lose its trained officers and was unable to recruit trainee replacements.

This year has declared a bumper dividend in that three officers returned to duty having been awarded the Certificate in Social Work of the Central Training Council following two year full time courses and, in addition, for the first time a social welfare officer who had not been trained by the authority was appointed to a vacancy on the establishment.

All these officers fill a dual capacity in that they are statutorily appointed to undertake social work duties deriving from mental health legislation. The overall position is satisfactory in that there are no vacancies on the establishment and Cumberland can take pride in having a much higher proportion of fully trained officers than is represented by the average position throughout England and Wales. Of the sixteen officers in post eight have recognised qualifications, three others have wide experience in social work but are technically unqualified and the remainder are awaiting admission to approved training courses.

The facilities for training courses leading to the Central Training Council's Certificate in Social Work have been significantly increased during the last few years in this long neglected field. At the same time it appears that there are still more than three applicants for every place which is available on approved training courses but the cumulative effect of the increasing provision for S.W. training is beginning to be felt and the formation of the Local Government Training Board will undoubtedly stimulate the secondment of untrained staff for training particularly by those authorities which previously felt unable to promote training.

b) Residential Staffs:-

During the year the authority took advantage of the courses organised by the National Old People's Welfare Council. An assistant matron who is a state registered nurse and who had previous relevant experience as a warden of a group dwellings scheme was seconded to the full fourteen week training course for matrons and assistant matrons. Four matrons and one assistant matron from the welfare homes for the elderly attended residential refresher or special emphasis courses of one weeks' duration.

The report of the Committee which was set up under the Chairmanship of Professor Lady Williams paid tribute to the National Old People's Welfare Council for pioneering both the 14 week course and short refresher courses for those involved in the residential care of old people. Nevertheless it was clearly recognised, following a detailed analytical survey of the present position, that adequate staffing of residential establishments in the future could not be hoped for without the promotion of more comprehensive training facilities leading to a defined career structure. It is, therefore, pleasing to learn that the Council for Training in Social Work has accepted an invitation from the Department of Health and Social Security to promote and approve courses of Training for the staffs of residential homes and suggests initially to provide one year courses for those holding senior posts in homes for the elderly, leading to the award of a certificate which, being issued under the conditions outlined in the Health Visiting and Social Work (Training) Act, 1962, will have national recognition. This is the first positive move towards the implementation of the

recommendations relating to training in the William's Committee Report. It becomes increasingly difficult to recruit senior staff for residential care work and this, in turn, will create further problems when secondments for training purposes come to be considered but with an eye to the future a clearly defined career structure for this type of work must emerge if a breakdown resulting from senior staff shortage is to be avoided.

The scheme which was introduced in 1965 by which suitable school leavers were appointed as trainees in the residential homes for the elderly continues with a fair degree of success. It has never been easy to attract suitable recruits and inevitably one or two have failed to measure up to the standards of suitability for further training during their initial assessment period, but at the time of writing three young women are receiving in-service training in a variety of welfare homes in the county and reports on their progress indicate their future potential for promotion to more senior positions. It has been most encouraging to note the outstanding success of two of the initial intake of trainees, both of whom are proving their capabilities as assistant matrons. It is most refreshing, and augurs well for the future, to see these two young ladies (both of whom are in their early twenties) assuming complete control of small welfare homes with an air of cheerful and confident efficiency during the absence of the matron. Great credit is reflected, not only on the girls themselves for their enthusiasm and devotion, but also to those many members of my staff whose guidance in their training has proved so fruitful.

Probably the highlight of the training year was a weeks residential refresher course which was held at Underscar, Keswick in the last week of March under the title "Care of the Elderly—The Changing Needs". This followed a pattern which has proved to be of value in the last year or two of bringing together the representatives of a variety of disciplines to discuss matters of common interest. The majority were senior staff engaged in the residential care of the elderly either in welfare homes or in geriatric or psychiatric hospital wards, but these were supplemented by a smaller body whose field of work for the elderly lay outside hospitals—welfare officers, health visitors, district nurses and voluntary workers. I am most grateful to the many distinguished

speakers who set the very high standard which permeated the course and included Professor Ferguson Anderson of the University of Glasgow, Mr. R. Ellerington, The Principal Regional Officer of the then Ministry of Health, Dr. W. Russell Grant from the Royal Hampshire County Hospital at Winchester, Dr. J. Adrian Gillet, Medical Officer of Health to the London Borough of Barking, The Lord Bishop of Carlisle and also those many colleagues in the region who gave so unstintingly of their time to make the course such an outstanding success.

In retrospect I will merely quote for the purposes of this report a few of my impressions:—

(i) It was most encouraging to hear the emphatic and continuing insistence which came from all quarters (hospital consultants, general practitioners, hospital and community nursing staffs, residential care staffs, social workers (whether in hospital or community based) and voluntary workers) for team work and the abandonment of effort in isolation in favour of integrated team work.

(ii) The demand from all disciplines for a comprehensive medical/psychiatric/social assessment of need leading to a plan of care.

(iii) Services for the elderly in any particular field can only be regarded as part of a wide (and widening) spectrum of care beginning with positive preventive measures and continuing on the basis of carefully assessed need through support in the home situation, in special housing, in residential homes and in hospital. Following this recognition comes the development of an easier flow throughout the range of care facilities to meet changing needs.

(iv) In spite of difficulties arising from shortages of material resources and trained staff there was expressed a common determination to work together by pooling effort to secure maximum advantage. In this context it was recognised that the ratio of investment between various types of services and material provision for the elderly must be under constant review in the light of changing needs and changing experiences

so that precious resources are not used merely to stop up a gap which may develop in one aspect of care until the relative values of alternative solutions have been carefully assessed.

(c) Police Cadets:—

The scheme which was started experimentally in 1967 to accept police cadets in their final year of training to give practical experience in the field of human relationships proved so successful that it has been continued (with some modification) during this year. Following a critical appraisal of the initial secondment a clearer pattern of training is emerging as a result of which the training period has been doubled (from 4 weeks to 8 weeks with a two week break at the half way stage). Two cadets completed this type of training during the year, one in the Northern Area and one in the Southern, and their programmes were designed to present every opportunity for active participation in work involving personal contact with the handicapped, inadequate and elderly in the community.

(d) Other forms of training:—

Staff meetings at approximately quarterly intervals have continued throughout the year. The Matrons of residential homes and the social welfare officers continued their conferences on a county wide bases to discuss developments, to consider new projects and generally to pool experiences. Both groups invite representatives of other sections of the department and the voluntary services to join them in their discussions to co-ordinate effort and to maintain effective communications.

Following a request from the Principal Probation Officer a 7 day course spread over a five week period was arranged for newly appointed probation officers. The object was to give them an outline of the functions of the health and welfare department paying particular attention to those aspects of care and support to the major groups at risk in the community and in which there were possible points of common concern and interest.

I feel it is incumbent upon the department to offer the opportunity for students to pursue their studies in the practical situation during their vacations. This of course is only effective if exper-

experienced and trained officers can be made available to devote adequate time to this type of exercise. Within these limitations a number of students have visited throughout the year and to illustrate this aspect of the work I would mention a one day study course arranged for eight students from the Department of Social Studies at the University of Newcastle upon Tyne who wished to discuss "at first hand that, within the basic statutory requirements there is room for flexibility in the organisation of the work of health and welfare departments" and a four week field placement which was arranged in the Northern Area for a sociology student from the Kingston College of Technology.

HOMELESS FAMILIES AND TEMPORARY ACCOMMODATION

In Cumberland the supervision and casework of problem families is diversified between the local branch of the National Society for the Prevention of Cruelty to Children, the Children's Department and the Health and Welfare Department. The rent guarantee scheme and the care of homeless children separated from their parents are Children's Department functions, while the responsibility for providing accommodation for the homeless families is shared between the County District Councils and the County Council.

The very low incidence of homelessness within the county has been maintained during 1968. In addition to the important role of the caseworker this problem has only been contained due to the sympathetic understanding of these families by the County District Councils, and the work of other agencies concerned. The fact that only 12 families had to be maintained under a rent guarantee reflects the important part played by the County District Councils. It is interesting to note that the rent guarantee scheme cost the County Council less than £2 per annum for each family supported in this way.

There is still a close family bond existing within this county. Most of the families who have problems of accommodation find a temporary home with near or distant relatives.

One of the problems of homelessness which usually requires the assistance of the social worker involves the agricultural worker who decides to leave the land for the more lucrative urban employment only to find that his family have to be evicted from their tied agricultural cottage. Heavy demands are also made on the caseworkers by families moving into the area to join their husbands who are working on the extension of the M.6 motorway.

Another interesting point is that sometimes the families do not consider themselves as being homeless. One such family consisting of man, wife and 9 children moved into the area and established themselves in a very dilapidated caravan and had to be persuaded to accept temporary accommodation in one of the special units at Wigton.

The demands upon the caseworkers' time are great in the prevention of homelessness and the rehabilitation of the homeless. An example of this is the fact that 208 visits were paid to the three families in the temporary accommodation units at Wigton during the year.

At the beginning of the year all 4 units which the authority provide for the temporary housing of the homeless were occupied by families who had been assisted in this way for periods varying from one month to two years. Between them they had 14 children, 6 of whom were under five years of age. One family (man, wife and 3 children) was rehoused by the District Council after two years in the temporary accommodation, and another family was found suitable private accommodation after just over a year in temporary quarters. Only one family was admitted to the authority's temporary accommodation during the year, but this consisted of unmarried parents and their 9 children of subnormal intelligence, who had established themselves in a dilapidated caravan in the extreme north of the county. Thus, at the end of the year the 3 purpose-built units within the grounds of Highfield House were all occupied, but the single terrace house at Aspatria was unoccupied and available for the purpose for which it was acquired.

With the "run-down" in the number of residents in the Part III accommodation at Highfield House, Wigton, in anticipation of their transfer to a modern purpose-built Home, a limited number of beds were available for the temporary accommodation of the homeless. One man, 2 women and 1 married couple were admitted to Highfield House and all moved out within two days to private accommodation, to relatives or to lodgings. A great deal of welfare work involving many agencies is directed towards the prevention of homelessness, and in trying to find solutions to these problems by means other than the offer of accommodation provided by the welfare authority, if the family despite preventive efforts find themselves without a home. Apart from the emergency which arises from "circumstances which could not reasonably have been foreseen" such as flooding, storm or fire, homelessness results from a number of reasons, eviction from a household following family disputes being the commonest single cause. Evic-

tions for reasons other than rent arrears, such as the termination of service tenancies or the expiry of leases take place quite legally. In 20 instances during the year the state of homelessness occurred and was satisfactorily resolved by my officers without recourse to the authority's temporary accommodation. These involved 7 couples, 13 widowed, deserted or unmarried adults and 42 children. Six of these families were given tenancies of Council houses by the District Councils, one was found private rented accommodation, 8 were placed in lodgings, and in the remaining cases some relative was persuaded to offer them at least a temporary home.

The advice given in the joint circular issued in 1967 by the (then) Ministry of Health, Home Office and Ministry of Housing and Local Government has been carefully noted, and has been under continuing discussion between the various departments of the County Council and the County District Councils in a mutual determination to minimise the problems and to take action in a constructive and co-ordinated fashion. I welcome this opportunity of expressing my personal appreciation for the generous contribution which is made by the County District Councils as housing authorities and their officers to this cause. The first point of attack must obviously be aimed at the prevention of homelessness, and in this direction the officers of the County Council work closely together and in concert with those of the District Councils to develop an "early warning" system so that families who seem to be running into difficulties can be given help quickly to prevent any worsening of the situation. That County Councils with statutory welfare responsibilities for providing temporary accommodation may be at a disadvantage in that they are not also housing authorities is a view that has received support from the Seebohm Committee, which sees "considerable advantage" in Housing Departments assuming responsibility for providing accommodation for homeless families, in the belief that the full range of housing responsibility should rest with Housing Departments, including the responsibility for dependent or unreliable tenants.

In this context and as is evidenced by the figures quoted earlier the County District Councils have been most helpful. However, when Highfield House is replaced in 1969 by a new old people's Home the East Cumberland Hospital Management Committee will

take over the premises, and they have expressed a wish that the homeless family units be also vacated. This will leave only one unit of accommodation owned by the welfare authority within the administrative county. I look forward with confidence to the outcome of discussions which are currently taking place whereby it is hoped that the District Councils will rent at least one house within their area on a permanent basis for use as necessary by homeless families. If this is achieved one patent disadvantage of the present provision—the concentration of this type of accommodation in one specific locality—will be overcome and the chances of the problem of homelessness being aggravated by separating a family from their normal area of residence and employment will be reduced.

REGISTERED HOMES

There are three Homes within the area of the administrative county which are registered by the County Council for the reception of disabled persons or old people as follows:—

Rothersyke, Egremont — 20 residents.

Springbank, Braithwaite — 10 residents.

Scalesceugh Hall, nr. Carlisle — 30 residents.

These homes are, of course, subject to regular inspection by members of my staff. Rothersyke and Springbank provide private accommodation for the elderly who are in need of care and Scalesceugh Hall is run by the Cumberland, Westmorland and Furness Spastics Society for adults suffering from cerebral palsy.

During the year an application was received for registration as a private home for the care of old people at Gosforth. The applicant is a State Registered Nurse with considerable experience in this type of work both in a private capacity and in accommodation provided by a local welfare authority. The registration was not finalised by the end of the year, but I look forward to these premises coming into operation shortly for the care of up to 10 elderly people. Facilities for the private care of old people are a necessary (and hence invaluable) contribution to the total range of residential services. Enquiries received not only from Cumberland but from other parts of the county suggest that there are many old people who could well afford private accommodation whose social needs, whilst justifying entry into residential care, do not qualify them for a very high degree of priority by comparison with the many other candidates for admission to local authority accommodation. It is, therefore, rather surprising to me that private enterprise has not developed along these lines to a greater extent—particularly in the northern and eastern parts of the county.

Section 44 of the Health Services and Public Health Act, 1968 came into force on the 9th of September, 1968. This enables local authorities to extend their powers under Section 26 of the National Assistance Act, 1948 to enable them to arrange for the accommodation of elderly and handicapped persons in registered

homes run privately, as well as in local authority or voluntary homes. This welcome provision cannot, however, be implemented until the authority's Scheme under Section 21 of the 1948 Act has been suitably amended and this procedure is being undertaken.

Supported Independency Schemes

The pattern of care for the elderly in the community has gradually changed as the needs of the elderly have changed and evidence continues to build up that the contribution made by these schemes in the spectrum of care is growing in relative importance. One of our principal objectives as a health and welfare authority is to organise supportive services from both statutory and voluntary sources which, supplementing that of relatives and friends, will enable the elderly to live out their lives in comfort and security without leaving their homes. Some inevitably will require a degree of support which can only be given under the full residential conditions which are available in the welfare homes. Between these two extremes are a number living in homes which are unsatisfactory either because they present structural difficulties which may be hazardous to old persons or because they lack basic amenities. Some elderly are 'at risk' because of social isolation or because their geographical isolation in this rural county makes it even more difficult to provide even modest supportive services. The probability is that those elderly who require a degree of support which it is not practicable to provide in their own homes will gradually deteriorate socially, physically and mentally and sooner or later become candidates for full residential care in a welfare home. Given the opportunity to enjoy all the amenities of a home which has been designed specifically to cater for the requirements of elderly tenants in a grouped dwelling scheme their independence is secured, the privacy and dignity of a home of their own is secured, companionship is readily available if desired and above all there is peace of mind in the security of the knowledge that help of every kind is quickly available at all times if it should be needed.

All these factors have been tested and assessed throughout the county during recent years but I suggest that whilst the consensus of opinion progressively upgrades the value of this type of pro-

vision, the relative value is of even greater importance in Cumberland because of the abnormal weakening of the familial infrastructure which follows the outward migration of the younger age groups from this rural county with its limited range of employment opportunity.

It is only seven years since the first grouped dwellings scheme for the elderly with warden over-sight was opened but by the end of 1968 twelve such schemes were in operation which together provided 286 places in 228 units. It is encouraging that ten of the thirteen district councils (as housing authorities), having been satisfied of the need for and value of this form of housing for the elderly and having accepted the County Council's Scheme for Financial Aid towards the welfare component of the grouped scheme, have translated this into positive action by providing one or more such schemes as part of their general housing development. Only one new scheme came into full operation during 1968—at Maryport where with the assistance of the County Architect the District Council developed a scheme on a difficult site which involved split level planning for 16 single person and 4 two person flatlets with communal facilities and warden oversight.

The year under review was, however, notable because of the progress made with the District Councils in forward planning towards additional grouped dwelling schemes. Seven further projects are now in the pipe line which together will provide a further 130 housing units for 170 elderly persons. At Millom a scheme for 10 units providing 12 places in flatlets associated with the new Millom Old People's Home is under construction and should be ready for occupation about mid summer. Five other schemes mounted by the Ennerdale Rural, Penrith Urban, Penrith Rural, Wigton Rural and Workington Borough Councils have been included in the programme for general housing development for 1969. There has been some local difficulty in securing an acceptable site for this type of development in Whitehaven but what appears to be an acceptable location has been provisionally allocated by the Borough Council for this purpose and it is probable that the first development in this area will take place during 1970. Many of these schemes are in an advanced stage of preparation and it is confidently expected that building will begin early in 1969 in at least 4 cases.

I have commented in earlier reports on the fruitful co-operation which exists between the District Councils (as housing authorities) and my own Department as the welfare authority in the promotion of supported independency schemes. I think it is most commendable that it is possible to work in complete co-operation in total planning and in detailed design but at the same time encouraging diversification of ideas and experiment in the design, layout and operation of these projects. In this context I would instance the problem of the Penrith Rural District Council which, whilst anxious to play its part in providing supported housing for the elderly found it difficult within an area consisting entirely of small villages to pin point a location in which a project of this type would be viable. Following discussion at officer level between the two authorities, it has now been decided to build a block of 12 flatlets which are to be linked with 6 existing bungalows (which at present offer no welfare support) to form a combined scheme with warden oversight and communal welfare facilities.

Finally my own opinions in this matter were confirmed in a Government Social Survey Study "Social Welfare for the Elderly" which was published towards the end of 1968 which comments that home help service and housing programmes for the elderly in most areas of the county could be at least doubled without resulting in over provision and that of old people in residential homes many could well have looked after themselves had adequate housing and domiciliary services been made available to them.

HANDICAPPED PERSONS

It is interesting to note that the number of persons registered with the authority because of "permanent and substantial" physical handicap has increased by a factor of $2\frac{1}{2}$ during the past five years as is shown in the following table:—

1963	...	...	278
1964	...	...	342
1965	...	...	415
1966	...	...	517
1967	...	...	614
1968	...	...	689

This rate of increase in registrations in no way reflects a growing incidence of the conditions which qualify for inclusion on the register, but serves as an excellent illustration of the effect of the combined approach to the care of the patient outside hospital through the medium of the family health care team. The family doctor, with his clinical responsibility for the patient, has the support of the local authority's nursing staff who are directly attached to the practice, and also of those social workers whose function is to bring into play any ancilliary services which will lead to a fuller life for the handicapped person and his family. provide an effective focal point of contact with the welfare services. In this teamwork situation the physical and social needs of the handicapped are more readily identified and planned care, which usually includes some component of service through voluntary agencies, can be more fruitfully organised. New registrations totalled 136 during the year, of whom 50 were aged 65 or over. Almost exactly one-third of the registered handicapped relate to those in the 65 plus age group, and nearly a third of those registered suffer from nervous diseases of organic origin, such as disseminated sclerosis or the after effects of strokes. The proportion of those registered because of arthritic or rheumatic conditions continues to increase—at the year end 125 out of the total of 689.

Two centres are available on a full-time basis for all forms of handicapped persons—one purpose-designed at Workington and the other an adapted building at Whitehaven. Seven other centres at clinics, educational establishments and rented accommodation

rattered throughout the remainder of the county are used on a part-time basis according to local need. These centres help to draw the disabled together so that they can enjoy companionship which would otherwise be denied them, and at the same time provide an effective focal point of contact with the welfare services. It would not be possible within the authority's limitations of manpower and finance to provide these social and recreational facilities to this extent without the very considerable support and assistance which is so readily forthcoming from voluntary sources. In this context, the true spirit of voluntary service to the community is clearly demonstrated in supplementing the limited statutory provision.

One function of the local welfare authority is to ensure that aids and appliances are supplied to those severely disabled who need them as substitutes for physical deficiencies. These aids and appliances can be made available from varying sources under the National Health Service and in some circumstances the local health and welfare authority has a permissive power to assist. The administrative arrangements for supplying an increasing range of necessary appliances have become complex to a degree that the British Medical Association found it necessary to appoint a working party to examine the existing procedures. I think some overlapping of responsibility may have arisen because of the fragmented way in which the overall provision has developed but these difficulties have largely been overcome locally by drawing up a practical working arrangement with the hospital and general practitioner services.

The Department arranges for adaptations to be carried out in the homes of the substantially handicapped for their comfort and convenience. These include such items as the provision of ramps, the widening of doors, fixing handrails and alterations, special fittings in kitchens, bathrooms, and toilets. Many of the District Councils (as housing authorities) bear the whole or a substantial portion of the cost of these works in their own property, but the County Council as the welfare authority is faced with heavy and increasing costs for necessary improvements to privately owned property which is rented to the severely disabled. It is most gratifying to note that to an increasing extent the District Councils

are making limited provision within their general housing programme for special housing for the severely disabled. At the present time my social workers, at the request of one District Council, are undertaking a complete survey of the more seriously disabled in their area in order that they may include in their general housing programme for 1969 a few bungalows specially designed for those requiring wheelchairs on a site appropriate for this purpose.

Towards the end of 1967 and with the goodwill of the local newspapers publicity was given to the car badge scheme for disabled drivers. This publicity, coupled with the efforts of my social welfare officers has resulted in the issue of 28 new car badges during 1968, the total at the end of the year standing at 84.

Holidays for the Disabled

For some years the Committee was happy to assist financially and to co-operate with the Cumberland Council of Social Service in arranging holidays for disabled persons, and it was with profound regret that it was not possible, because of the very difficult economic climate, to lend the Council's financial support to this enterprise in 1968. In spite of this, the Secretary of the Cumberland Council of Social Service was able to report as follows:—

“We have just completed another successful group holiday at Rhyl for 65 people and have also arranged 3 family holidays, and we were particularly happy at having Miss Mansbridge (your former Superintendent Nursing Officer) as one of the helpers. Members of the British Red Cross Society and St. John Ambulance Brigade also accompanied the party and 4 young members of International Voluntary Service went along as supplementary helpers entirely financed by their own organisation. The loss of your authority's grant meant that we had to ‘scrape the barrel’ a little and the holiday for the disabled fund is now pretty well exhausted. It goes without saying that we should be very grateful indeed if your Committee could feel able to resume its grant for these holidays as soon as the financial position is sufficiently improved”.

This highly successful effort has developed from very small beginnings over the years, and serves as yet another illustration of the complementary role of voluntary organisations to that of the provision by the statutory authorities in providing a more effective service. In this instance, the Council of Social Service raises the money and undertakes all the detailed arrangements and organisation concerning the holidays. My own officers play a relatively minor role—their task being to nominate those clients who are considered to be in greatest need of a holiday and, to a very limited extent, to assist the administrative arrangements.

Blind and Partially Sighted Persons

The following table shows the age groups of blind and partially sighted persons registered on the 31st of December, 1968:—

Age Group		Blind			Partially sighted		
		M.	F.	Total	M.	F.	Total
0—1	...	—	—	—	—	—	—
2—4	...	2	—	2	—	—	—
5—15	...	4	—	4	11	4	15
16—20	...	—	2	2	3	4	7
21—49	...	29	18	47	16	12	28
50—64	...	31	36	67	14	12	26
65 and over	...	121	238	359	39	54	93
TOTAL	...	187	294	481	83	86	169

During the past five years there have been a gradual decline in the numbers of persons registered as blind (from 529 in 1964 to 481 at the end of 1968) and during the same period the number of those recorded as partially sighted has fluctuated between 156 and 176. Since the last report the number of blind decreased by 48 and the partially sighted by 7. Rather more than 74% of the blind and 55% of the partially sighted are over 65 years of age and it is easily understandable that most of the removals from the register are because of death.

The pattern of supportive services in this county remains unchanged. For many years it has been found impossible to recruit qualified home teachers of the blind. Four such teachers

cover the county area but to a gradually increasing extent all total caseloads have been carefully screened so that those requiring social support involving a lesser degree of skill or specific training in blind welfare are supervised by social welfare officers in the main. This has been found to work satisfactorily and enable the home teacher to devote more of her time to those blind and partially sighted who require home tuition or whose case work problems are better dealt with by a social worker with more specialised training in relation to the blind. The Barrow, Furness and South Cumberland Society for the Blind continues to act as agent for the County Council in the provision of services for the blind in the extreme south of the county area (south of the River Esk).

Craft and social classes are held at 13 centres throughout the county under the supervision of home teachers of the blind and/or social welfare officers. A class in choral singing for the partially sighted is also provided by arrangements with the local education authority (which provides the tutor) as part of the further education service. To meet a rather specialised need in a remote part of the county area a craft class for the blind and handicapped is also held at Alston in one of the smaller residential homes for the elderly.

Workshops for the Blind

It was the aim of the Joint Sub-Committee of the Councils of the City of Carlisle and this county which undertook the administration of the Workshops for the Blind from the voluntary organisation in 1962 to modernise the workshops along industrial lines, and so provide more satisfying employment by improving working conditions. This policy has continued and has resulted in the concentration of production towards articles for which there was a more ready market, and this necessitated the closure of small departments that had previously been engaged along traditional lines producing goods for which there was a declining demand. The workshops have shown an encouraging increase in production (as measured by sales) as is shown in the following table:—

Table "A"

Year		Sales	Number of Employees (including trainees)
1963	...	£18,967	30
1964	...	£24,023	33
1965	...	£30,219	37
1966	...	£34,368	32
1967	...	£35,693	33
1968	...	£39,030	32

The production loss per worker compares favourably with the national average for similar workshops, but it is felt important, in the interests of overall efficiency, to maintain a continuing and careful analysis of the productivity and profitability of individual departments. Simultaneously a close check is kept on overhead costs, including those relating to selling and distribution and general administration. I am grateful to Mr. Swinfen of the Department of Employment and Productivity, and to the Industrial Advisers to the Blind Limited for their advice and guidance.

Following these consultations it was decided to remove some internal partitions within the workshops to make more work space available and to simplify supervision. To provide more storage space and to minimise the handling both of raw materials and finished products it was thought advisable to convert the loft over

the main workshops to storage purposes. Provision for these alterations was made in the 1968/69 budget on the assumption that a capital grant of about 75 per cent of the total cost would be made by the Department of Employment and Productivity. On more detailed examination of the proposals the conclusion was reached that by removing certain internal partitions and by providing a new teasing room the additional storage space which was required could probably be achieved by a redistribution of the working areas, and it was accordingly decided not to proceed with the rather expensive conversion of the loft space for storage until there has been operational experience resulting from the other alterations and the effect of these on the overall storage position.

For some time it had been apparent that the Basket Department (in common with similar Departments in other Workshops for the Blind) incurred a relatively high manufacturing loss by comparison with other departments, and it was closed during the year. The foreman is being retrained as an upholsterer and one other basket maker was absorbed in the Upholstery Department. A long serving basket maker retired and another was accepted for training as capstan lathe operator with a view to his employment later in open industry. This left only the expert rush seater who is continuing in his trade so long as reasonably economic work is available.

I thought it necessary during the year to remind the Joint Sub-Committee of a continually declining need to provide facilities for the sheltered employment of the blind. This fortunate provision arises from a reduced incidence of blindness, coupled with greatly improved facilities for training to enable them to be placed in open employment. This means that if a relatively small workshop is to remain viable the proportion of sighted disabled to blind persons must increase. I illustrated this position statistically by reporting that during the past five years only three blind people have been found sheltered employment at the workshops and that in the same period the proportion of blind to disabled persons has declined from a ratio of 9 to 1, to 2 to 1. Running alongside this happy position so far as the blind are concerned there is an obviously increasing need to find sheltered employment

for those handicapped in some other way, and of the other types of handicap the needs of the mentally disordered loom largest. With the approval of the Committee I discussed this situation with my colleagues in the psychiatric field and as a result there are regular case conferences between my staff and those of the Garlands Hospital, together with the Group Disablement Resettlement Officer, to assess the viability of patients from that hospital for training at the workshops. Arising from my meetings with the consultant psychiatrists it seemed clear that the rather complicated procedures which were necessary before a sighted disabled person could be accepted for training for sheltered employment tended to militate against the purpose of the scheme, and I am pleased to report that, following representations to the Disabled Persons' Branch of the Department of Employment and Productivity it was agreed that, for an experimental period the existing procedures would be short-circuited by authorising the local Disablement Resettlement Officer to approve admissions without referral to the Regional Office or to the headquarters of the Department. It is interesting to note that in a circular from the Department of Employment and Productivity (relating to capitation grant for those provided with sheltered employment in these workshops) reference is made to the "generally lower capacity of workers now coming forward for employment in them". This lowering of potential has certainly been felt locally and is evidenced by the fact that of the 11 severely disabled persons who were referred for training to the workshops (of whom only 1 was blind) 2 successfully completed their training courses and are now approved workers; 2 are still under training, but 7 were found to be unsuitable either because they failed to achieve the minimum standards or because they proved to be medically unfit.

Finally Major C. W. Holt, Manager of the Workshops for the Blind, makes the following report:—

"During 1968 in consultation with employees development plans have been formulated for improvements in factory layout and organisation. A searching look at the layout revealed that much space was being wasted by the existence of many small rooms and the central corridor space. It was decided to recommend that an 'open plan' factory would be

more efficient than the present layout. Implementation of this plan is now under way and preliminary work has been completed. It is expected that this, together with other minor changes, will increase efficiency. Production is confined to brushes (mainly for supply to Contractors and Local Authorities) divans, mattresses, cushions and pillows and upholstery. Efforts have been made to attract new types of work for the factory especially in packaging lines and we have had some success in this field. A start has been made in co-operating with other centres for the handicapped in the area for them to manufacture wooden components for divans and upholstery frames.

The trend of sales during the first half of the year showed a steady increase but a 'fall off' due to seasonal demand and the economic climate occurred in the latter half of the year.

Visits have been made by Management and selected employees to other workshops to view developments at these establishments. We have had many visits from the general public and I would like to thank them all for the keen interest they have shown in our work".

Blind Home Workers

A young man of 25 who was registered blind in February 1967 was admitted to the Council's Approved Scheme for Blind Home Workers during the year. With the noteworthy support of his family, and the advice of the Department of Employment and Productivity's specialist officers, my social workers were able to direct their efforts to the establishment of the client in his own business. His wish was to establish a pet food shop and, following local market research which indicated that such a venture could be regarded as viable, a combined house and shop was acquired. This is well sited and the respect and admiration for his efforts is being reflected in the locality in his growing patronage and I think there is little doubt but that he will be successful in this venture and require augmentation of his earnings which the scheme provides at a reducing rate.

One who has been self-employed as a pig keeper since 1962, after overcoming difficulties in the earlier years, has now recovered satisfactorily and now requires augmentation of his earnings by less than the maximum amount. The remaining blind home worker sustained trading losses in his business as a small holder during two consecutive years and after very careful consideration the Committee decided that he be retained within the Scheme for another year. The Regional Technical Officer was consulted and an advisory officer of the Ministry of Agriculture, Fisheries and Food was called in to advise. The present indications are that the tide has been turned and it is expected that a trading profit will emerge from this financial year's working.

The revised scheme of augmentation for blind home workers which was recommended by the Local Authority Advisory Committee was adopted by the Council with effect from the 1st January, 1968.

Sheltered Employment

The authority's Scheme for providing sheltered employment and training for such employment made under Section 3 of the Disabled Persons (Employment) Act, 1958, is limited at present in its application to the physically handicapped in providing sheltered employment for up to 12 sighted disabled persons at the Workshops for the Blind and Disabled at Carlisle.

There has been no development in this area of responsibility during 1968 and I can only repeat the concern which I have expressed in earlier reports that the facilities for training and subsequent employment of those disabled people whose ability to work is limited by their handicap is most inadequate in this part of the country owing to its geographical isolation.

With the help of the disablement resettlement officers, it has been established that within a reasonable catchment area in West Cumberland there is a sufficient number of seriously handicapped men and women to justify the establishment of a sheltered workshop in that area. This project, to be located within a developing industrial complex at Lillyhall, is provisionally included in the Capital Development Programme for 1970/71.

Deaf and Hard of Hearing

The Carlisle Diocesan Association for the Deaf has continued to act as agent for the County Council by providing welfare services for the profoundly deaf in accordance with the Council's approved scheme.

The area of operation of the Association consists of the counties of Cumberland and Westmorland, the Furness area of Lancashire, and the County Boroughs of Barrow in Furness and Carlisle. The cost of this provision is borne by the local authorities on a pro rata basis related to the number of adult deaf on the caseload in each area. This year marks the seventy-fifth year of work with and amongst the deaf by the Diocesan Association, and on behalf of the County Council I would like to offer sincere thanks and congratulations in achieving this milestone of service so significantly pioneered and continued with unflagging devotion since before the turn of this century.

The numbers of profoundly deaf vary but little from year to year, and at the end of 1968 the total was 108 which figure includes 18 under 16 years of age who were attending special schools for the deaf and partially deaf. A regular service of home visiting, especially for the housebound, has been maintained by the Association's officers and interpreters are always available to help facilitate communication between the profoundly deaf and others. The social centres where the profoundly deaf can participate in communal activities continue to flourish at five centres throughout the Diocesan area including two (at Workington and Whitehaven) within the administrative county.

Mr. J. M. Barber, the Organising Secretary comments:—

“The handicap of deafness should be clarified in the context in which I am writing. I refer to that group of people who were born deaf or who became deaf before they reached the age of speech, and in this context deafness is not only the inability to hear but because that person has never heard he has a language problem (not a speech problem) which leads to misunderstandings, frustrations and comprehension diffi-

culties which colour his whole life, his outlook and his behaviour pattern, which in turn result in emotional and social problems. Shouting in their ears with vague waves of the hand, together with overemphasised mouthings do not, as is commonly thought, do anything to overcome this handicap where the most fruitful method of communication lies in use of the manual method.

Frustration, strain and misunderstanding dog their lives, but at the social centres for the deaf they can come and relax. There are no misunderstandings and no strain—they can sit and simply talk in just the same way as their counterparts in the hearing world go to their pubs and clubs, Townswomen's Guilds and Women's Institutes. In a world which is governed by the hearing, here at least they will have a say in how the centre will be run, what programmes are to be arranged, which guests to invite, where the next bus outing will go, and they have the satisfaction of full representation and participation. It would be foolish to think that these centres cater only for the older deaf. In spite of modern methods of education, loop induction systems, group hearing aids and so on, there are still children leaving school who cannot speak and whose method of communication is by the manual method. These young deaf use the social centres as their youth club and mix freely with the older members of the community.

These centres serve as invaluable focal points of communication because the deaf person knows that whatever his problem, whether it be financial, in relation to employment, the need for the help of a solicitor or with house purchase, or a quarrel with a neighbour, not only advice but the services of an expert in communication between the deaf and the hearing are available through the officers of the Association".

My own social workers naturally look to their colleagues in the Diocesan Association as being the more expert caseworkers amongst the deaf in the community. At the same time, handicaps frequently take a multiple form, and I am very pleased to record the excellent degree of mutual support and co-operation which

exists between the authority's social welfare officers and their colleagues whose work is mainly related to the deaf. A similar degree of co-ordination and co-operation exists, I am happy to say, with the peripatetic teachers of the deaf provided by the education authority. Those severely deaf children whose disability is such as to require some special form of education are well-known to the Association's officers long before they pass outside the educational field so that, if necessary, a smooth continuum of service is brought into play in the difficult period of transition from school days to adult life.

A situation which has caused difficulty in the past continues to cause concern and shows virtually no promise of improvement. I refer to the fact that recruitment to this specialised form of social work falls very short of present requirements, and does not even keep pace with natural wastage so that the future outlook is indeed bleak. In an attempt to maintain adequate staffing, the Diocesan Association has, for a few years, made provision for a trainee on its establishment, and although two young people with the necessary academic background have undergone preliminary "in service" training, neither has been found suitable for progression to more formal training. It seems fairly obvious to me that the welfare officer for the deaf must first of all be trained as a social worker, and that this basic training must be supplemented by further training to equip them more adequately to meet the specialised needs of the deaf. This broadly is the proposal which was made by the Council for Training in Social Work to prepare social workers for services with the deaf and partially hearing. These arrangements suggested two alternatives:—

- (a) a recognised course of professional training in social work followed by a nine month course leading to the Certificate for Social Workers with the Deaf or
- (b) certain two year certificate in social work courses providing the facilities for teaching methods of communication, followed by a six months course leading to the Certificate for Social Workers with the Deaf.

Whilst the desirability of these proposals cannot be faulted the simple facts are:—

- (i) that the recruitment of young people with the necessary academic background for basic training in social work falls short of requirement.
- (ii) that the facilities for training cannot even cope with the present inadequate recruitment.
- (iii) that trained social workers no matter how vocationally inclined towards work amongst the deaf are unlikely to submit themselves to further expense and effort which is inherent in supplementary courses of study unless they can look forward to a fair recognition (in terms of salary) of their additional expertise.

Despite continuing efforts by my medical staff and social workers the Hard of Hearing Club which was inaugurated at Wigton in 1965 held its last meeting in September. Although 72 potential members within a reasonable travelling distance of Wigton were constantly invited the average attendance at the club was about 12, whose average age was nearly 60 years. The club met monthly on a Friday evening—since the majority were occupied at work or in the home during the day, and there was ample evidence that the members are well integrated into the community and have many other interests in that the club attendance was noticeably affected by any local “counter-attraction” which fell on a club evening. When talks, films and discussions on the technical and clinical aspect of deafness had been exhausted there was virtually no response to social activities organised by my officers, nor any willingness on the part of the membership to take part in the running of these activities. In the bigger conurbation of the City of Carlisle and its immediate surroundings there has been an exactly parallel reaction. The conclusion which can be reached is that isolation from the community is not evident so far as the hard of hearing are concerned, whose main needs seem to be related to initial guidance in the use of hearing aids and easy access to facilities for their maintenance.

I cannot close this section of my report without making reference to the Seebohm Report and its possible implications so far as the present local services are concerned. In this context I would, at this stage, merely endorse the opinion expressed by the Diocesan Association that there is a continuing need for specialisation in the area of social work amongst those born deaf if their paramount need (the services of a specialised officer with great skills in communication for the deaf) are to be fully met.

Day Centres, Luncheon Clubs and Meals on Wheels

The importance of these community supporting services for the elderly cannot be overstated. Each has a triple function. These are:—

1. To make a significant contribution towards the maintenance of the elderly within the community.
2. To serve as a relieving service to supplement the services provided by relatives and friends.
3. To meet a temporary need.

Day Centres

The provision of day care facilities in the authority's welfare Homes was increased by 32% during 1968 and was achieved by extending the number of Homes offering this service from six to eight. I understand that in some parts of the country the residents of welfare Homes regard the admission of day care elderly as an intrusion of their privacy. This view when expressed should be respected but I am pleased to say that this is not the attitude taken to the day care elderly by the residents in Old People's Homes in this county. Here they look to the day care elderly as an important source of contact with the community, especially by the ever increasing group of residents who because of their infirmity are more or less unable to go out of the Home. On the other hand, few of the Homes have been designed with the provision of day care elderly in mind and this has greatly retarded the growth of this service. The Homes now being planned make provision for day care, but the number in each Home is restricted to a

maximum of 30% of the number of residents. This provision is being planned in such a way that those in day care can either be integrated or separated from the residents should there be a change in attitude.

Selection of the "at risk" elderly for this service is by a member of the family care team led by the general practitioner. Frequently they are on the waiting list for admission to a welfare Home, and day care acts as a gentle introduction to the very different life as a resident. In many cases day care for as little as one or two days a week can so influence the individual situation that the need for full residential care assumes less urgency, and may even no longer be considered necessary.

Luncheon Clubs

There are thirteen luncheon clubs held throughout the county. The Women's Royal Voluntary Service organise five such clubs, Cumberland Old People's Welfare Committee six, and the remaining two are organised by the matrons of Old People's Homes. During 1968 the Cumberland Old People's Welfare Committee opened two new clubs at Frizington and Whitehaven, whilst another of their clubs at Ehenside School, Cleator Moor was regrettably temporarily closed for the last six months of the year. The luncheon club at Brackenthwaite was replaced by the more comprehensive day care services at that Home. A total number of 13,509 meals were served at lunch clubs during the year, representing a 3.6% growth during the year.

Meals on Wheels

About 560 elderly are assisted by the meals on wheels service involving a total of 53,569 meals served during 1968. This service is provided on an agency basis by the Women's Royal Voluntary Service involving some 500 voluntary workers who give so unstintingly of their time and energy. The school meals service and Old People's Homes each supply about a third of these meals and the remaining third are supplied by inns, pubs and canteens.

The cost of this service to the recipients has been maintained at 1/3d. per meal. Referrals for this service come to the Women's Royal Voluntary Service from all quarters, but these are then passed back to the health visitor for investigation. This leads not only to the standardisation of qualification for the service, but it usually follows that an elderly person in need of the meals on wheels service also requires other community health services which can be arranged by the health visitor.

During the week ended 26th May, 1968 a national survey of the meals on wheels service was undertaken by the then Ministry of Health. This revealed amongst other things that the rate of provision of this service within Cumberland was 19.1 persons per 1,000 of population aged 65 years and over. This compares very favourably with English counties as a whole with 17.0 persons per 1,000 and England and Wales with 16.6 persons served per 1,000.

MENTAL HEALTH

MENTAL HEALTH

An outstanding feature of the Department's activities in the Mental Health field during 1968 was concerned with staff training—both locally here in Cumberland and in the pursuance of vocational training through national courses.

The 10th one week staff training course in October 1968 at Keswick was on the general theme of mental health and was entitled "Mental Health Care—Community and Hospital—Communications". The emphasis of the course was on clinical and interdisciplinary co-operation. The drawing together of staffs serving the hospital needs of the psychiatric patient, including matrons, assistant matrons, tutors, charge nurses, ward sisters and medical social workers with staff serving the community needs of the mentally ill patient, including mental welfare officers and supervising staff from after-care hostels was a most rewarding exercise. The barrier of the border between Scotland and England was again successfully overcome and 37 officers from as far north as Dumbarton and as far south as Scunthorpe attended together with 10 Cumberland area and headquarters staff.

The principal speakers were from the then Ministry of Health, The Scottish Home and Health Department, the various Regional Hospital Boards, general practitioners and the Health and Welfare Departments in the northern region. I wish to record my appreciation for the very willing co-operation which I receive from the various local Hospital Management Committees with these courses both in the form of speakers and in the secondment of staff as course members.

Three social welfare officers, Miss L. O'Hare, Mr. Davidson and Mr. J. Allison returned from training during the year having successfully completed two year full-time courses and each were awarded the Certificate in Social Work by the Central Training Council. Of the 16 fieldwork staff, 8 have recognised qualifications, 3 are accepted as qualified by experience and plans are in hand for the remainder to be seconded to approved courses.

Miss A. Carruthers successfully completed a two year course of training and was awarded a Diploma by the Training Council

or Teachers of the Mentally Handicapped. She was appointed as an assistant supervisor at Hensingham Junior Training Centre.

A new day care unit at Dovenby Hospital which opened in 1968 admitted 4 severely subnormal adults from the community during 1968. It is expected that some adult trainees who at present attend the Distington Adult Training Centre, but who are so subnormal as to be considered as unlikely to benefit from training at that centre, shall be transferred to the more appropriate day care unit at Dovenby.

The following table is compiled from statistical information initially prepared for the Ministry of Health and shows a comparison over the past eight years:—

ANNUAL REPORT

Caseload at year end				1961	1962	1963	1964	1965	1966	1967	1968
Mentally ill and psychopathic	...	...	...	115	250	292	328	396	447	452	431
Subnormal and severely subnormal	...	...	...	351	359	391	437	449	511	497	483
Elderly mentally infirm	...	...	...	—	—	—	—	—	62	54	75
TOTAL				466	609	683	765	845	1020	1003	989
On training centre registers				71	86	95	119	135	162	168	174
Awaiting admission to training centres	...	...	...	42	46	42	45	39	3	10	5
In local health authority residential care	...	...	...	18	21	16	33	25	38	61	60
On hospital waiting lists (subnormals):—											
Urgent cases	...	...	...	—	1	1	4	1	—	—	—
Others	...	...	...	—	39	46	31	20	13	12	11
New cases referred:—											
Mentally ill and psychopathic	...	...	...	194	235	211	230	223	202	184	140
Subnormal and severely subnormal	...	...	...	35	71	42	86	62	70	40	37
TOTAL				229	306	253	316	285	272	224	177

It will be seen that the total number of patients under local authority care reached a peak in 1966. This is partially due to the fact that until that year a significant number of subnormal and severely subnormal patients resided within the county unknown to this department. Until this year there was a tendency for the department to keep a number of subnormals on the active case-load even when it was apparent that the individual was well integrated and self-supporting within the community. This is the major factor in the reduction by 2% in the number of subnormals under the care of the local authority.

Training Centres

The histogram on page shows that there was a drop in the total number of attendances of 955 or 3.1% at both adult and junior training centres during 1968, as compared with 1967. Small variations of this nature are to be expected where one considers the high level of provision of service that exists within this county, and the fact that there has been no expansion of that provision since early 1966.

Junior Training Centres

The provision of modern training facilities for children has been given a high degree of priority by my Committee. With the opening of the Hensingham Junior Training Centre in 1966 the provision, measured in terms of places per thousand of population was 0.52 per thousand. This compares very favourably with most other authorities. The development programme for England and Wales as a whole only aims at providing 0.54 places per thousand of population by 1976. The major difficulties caused by the vastness of this county have successfully been overcome by linking the other Junior Training Centre at Wigton with hostel provision for 22 children at Orton Park. This ensures that every child within the county in need of this service can at present be served. The children who have to be accommodated at Orton Park to enable them to attend the training centre return to their homes at weekends and holidays and are not, therefore, parted from their families for lengthy periods.

The Hensingham Junior Training Centre has facilities for 75 children including a special care unit for 10 severely subnormal children with gross physical handicap. A total of 64 children were on the register at the commencement of the year but this fell to 52 by the 31st December, 1968.

During the year five of the senior trainees were transferred to the Adult Training Centre, one junior to Irton Hall School for Spastics, one to Dovenby Hall Hospital and another child moved to another county. The indications are that apart from the demand for special care facilities this centre will meet the needs of the more densely populated areas of Western and Southern Cumberland for the foreseeable future.

Miss Love, Supervisor and Mrs. Martin, Assistant Supervisor both regrettably had lengthy periods of ill health during the year. Mrs. Martin unfortunately resigned on the 18th November, 1968. It is hoped that Miss Love will be able to take up her duties early in the New Year. Miss Carruthers successfully completed the Diploma course run by the Training Council for Teachers of the Mentally Handicapped, and was appointed as an assistant supervisor commencing 1st August, 1968. Three of the staff at this centre are now qualified teachers.

A healthy parent teacher relationship is encouraged and this year more parents have visited the centre. These visits help the teacher to build up a closer understanding of the individual child. Commenting on some of the 'extra mural' activities in which parents share, Miss Bowie, Acting Supervisor, writes:—

"On the 27th June in glorious weather we had our summer outing and again the children voted for Ravenglass, the 'Ratty Railway' being the great attraction. 45 children including 4 special care children, 9 staff and helpers and 4 mothers enjoyed a perfect day.

The children gave their 'Christmas Entertainment' to parents, friends and members of the Committee on the 17th December. After many weeks of preparation for the Nativity Play and various other items, it was very gratifying to all concerned to have such a large responsive audience present.

The Christmas Party was held on the 19th December, and all the children each received a gift from Santa, plus a very nice gift donated by the Parents' Association.

A gift of five pounds from the Gainsborough School of Dancing was used to purchase long playing records chosen by the senior boys and girls".

The Wigton Junior Training Centre which is also purpose-built is designed to accommodate 45 children. There is no special care unit provision at this centre. At the beginning of the year 35 children were on the register, but this fell to 32 by the year end. 4 senior children were transferred to Distington Adult Training Centre during the year—2 to Dovenby Hospital, 1 left the county and 1 child died. A further 3 senior girls left during the year but unfortunately because of transport and other difficulties they are not at present able to attend either Distington Adult Training Centre or Carlisle City Council Adult Training Centre at Kingstown. There were 8 admissions, including 2 short-term admissions during the year and at present there are only 3 known possible admissions planned for early 1969. From the evidence available it is estimated that the Wigton Junior Training Centre will meet the demands in the northern area of the county.

Miss Lister, Supervisor, writes:—

"In addition to the regular yet varied syllabus, through the medium of a movie projector and educational films, we introduce the children to a wider field of experience in the hope of increasing their knowledge and interest.

Voluntary help from the local grammar and secondary modern school girls aged 14 to 17 years continues to play a helpful part in the social life of the children. 6 girls using a rota system participate in the play-time activities after lunch each day for half an hour. This they do during their own lunch break. A further three girls, with the full co-operation and consent of their respective teachers spend 1½ hours each in the classroom handicraft lesson under the supervision and guidance of the teacher in charge".

In view of the fact that 21 of the children attending this centre are from the more outlying parts of the county necessitating their stay at Orton Park Hostel, it is more difficult to foster a strong parent teacher relationship. Strenuous efforts are made to encourage the parents to visit the centre at any time, and centre supervisors are encouraged to visit the child's home when necessary. An Open Day was held in June. The Sports Day was "rained off" but this gave the teachers a further opportunity to talk with the parents.

Of the coach outing along the Solway coast in July, Miss Lister writes:—

"A little time was spent on the beach at Allonby. The weather again was showery but this did not deter us. Once the sand was in sight buckets and spades emerged and the 'fight' was on. A picnic lunch was enjoyed during a break in the weather.

Also, in December we were invited by the headmaster of Wigton Secondary Modern School, to form part of the audience at their Christmas pantomime. The children responded very well and I think enjoyed the experience".

The Report of The Committee on Local Authority and Allied Personal Social Services, (Seebohm Report), which was published in July, 1968, recommended amongst other things that the "local education authority should become responsible for the education and training of all subnormal children and should take over the junior training centres". They based their conclusions on:—

1. "It is now agreed that there are no sharp lines between the 'educable' and the 'ineducable'.
2. Parents would welcome an end to the administrative categorisation of their children as 'ineducable'.
3. Such a step would also ease the re-assessment and transfer of children to other special schools and vice versa.

4. Education departments may be better able to recruit and train staff and improve teaching methods and equipment.
5. The administration of these centres should be more like schools.
6. Inclusion in the education service should permit freer movement of staffs between training centres and schools, particularly nursery schools and schools for other severely handicapped children.
7. The name 'junior training centre' should be dropped and some variant of 'special school' adopted".

The possibility of a transfer of responsibility for junior training centres has been under consideration for some time by the then Ministry of Health and the Department of Education and Science, so it came as no surprise when the Prime Minister announced in the House of Commons on the 26th November, 1968:—"After careful consideration of the views expressed by the bodies consulted, the Government have decided to accept in principle that responsibility for the education of mentally handicapped children in England and Wales should be transferred from the Health to the Education Service".

Mrs. Eland, Assistant Supervisor, Wigton Junior Training Centre writes:—

"The Government have decided that these training centres must eventually be the responsibility of the Education Service, so it would seem to be a good time to take stock of what the Health Service has already done with particular reference to the Wigton Junior Training Centre.

Over the years the number of trainees has increased from approximately 7-10 to over 30, and they have been transferred from one small church room to a purpose-built centre which has already been extended. The increase in numbers has been made possible by reason of a hostel taking an average of 20, and special door-to-door transport. For these reasons we now have children from all parts of Cumberland who would otherwise have had no training.

From being an occupation centre we have progressed to being a training centre with a curriculum of progression based on that in any primary school.

The present staff of 4 are unique in that all are trained nurses and 3 are qualified to teach mentally handicapped children."

Special Care Units

A very limited service for the day care of children who are severely subnormal, coupled with a gross physical handicap, is provided at Hensingham Junior Training Centre and Orton Park Hostel. The problems of providing this service in a sparsely populated county are immense. One of the main problems is transport. Most of these children cannot travel by normal transport. Thanks to the efforts of the Parents' Association and Messrs. Myers and Bowman Limited, Distington, 6 specially designed bus seats have been made and gifted to the Hensingham Centre. Two of these seats were gifted by the Parents' Association during 1968.

The Hensingham Junior Training Centre has 10 places for such children. During 1968, however, 15 children were registered at Hensingham for this service. To meet this demand a rota system was devised. Four children attend full-time, 9 for 3 days each week and 2 for 2 days per week.

The Orton Park Hostel Special Care Unit unfortunately is only open on one day each week and provides 6 places. The demand for these places built up during the year from 4 to 6. The transport to this unit is provided by the ambulance service.

As most of these children are non-ambulant, doubly incontinent and have to be fed, the demands upon the staff are great. The value of this short respite to the parents, however, more than compensates for their efforts.

Adult Training Centre

When the development of adult training facilities were being planned for West Cumberland it was decided that Distington was the ideal location, as about 70% of the West Cumberland population is located within an eight mile radius of Distington. The building was designed as a two-phase project to meet the growing demand for the service. The first phase was the building of a 50 place centre for both male and female adult trainees. Some of the services, however, e.g. kitchen and hall/dining room, although built during the first phase were designed to serve the additional 30 trainees to be provided for in the second phase. The 50 place centre was opened early in 1965, and it was then planned that the second phase of the development would be included in the Council's development programme for 1966/67. Loan sanction from the then Ministry of Health was not granted until the financial year 1968/69. This delay has created some problems during the current year which started with 65 trainees on the register. At the end of the year there were 63 trainees registered.

Semi-industrial occupation and continuing social and further education training are pursued side-by-side in the centre. The demands upon the trainee are always kept within his or her physical and mental capacity.

The semi-industrial occupations during 1968 include:—

1. The fabrication of garden interwoven fencing panels of various sizes. 1,805 panels were produced.
2. The manufacture of 2 ft. x 2 ft. concrete slabs. 1,334 slabs were made.
3. 30,280 wire coat hangers were made.
4. 330,000 forms were printed for various departments of the County Council.
5. Some hospital supplies such as safety pins, spigots, gallipots and glass connections were packaged ready for autoclaving, but the availability of this work was intermittent.

6. Some parts for motor car safety harnesses were packaged for a Carlisle firm. This work was most suitable for all grades of trainees, but regrettably in spite of the fact that the standard of the work done at the centre was highly praised the availability of the work did not materialise as expected.
7. 682,700 washers were fitted on accumulator plugs for a Maryport firm.
8. 3,000 bases were screwed on pepper and salt cellars for another Maryport firm.
9. 19,450 builders' wall ties were made by the trainees.

It is gratifying to know that this year for the first time trainees have been placed in both open and sheltered employment. A young man after two years at this centre was placed at the Remploy factory, Cleator Moor, and a young woman was placed in hotel work after some four years at Distington. A further 3 males and 2 females will soon be ready for open employment. When one considers the high rate of unemployment which has continued for so long in West Cumberland this is indeed success.

Since 1965 each trainee has received 2/- per day as an incentive payment. During 1968, however, an additional merit payment ranging from 3d. to 1/- per day was given to certain of the trainees to acknowledge their efforts.

To meet the need in the less densely populated northern and eastern parts of the county a second adult training centre was planned for development during 1969/70. Regrettably this has had to be deferred because of the national financial stringency. It is now provisionally included in the Department of Health and Social Security's programme for 1970/71, but it is thought that this will be further deferred. The location of an adult training centre in East Cumberland is dictated by the transport that would have to be involved, and logically this dictates that the site must be in the Carlisle area. It is also evident that this provision will have to be linked in due course with adequate hostel accommoda-

tion for both male and female trainees. Pending the provision of these services in East Cumberland, with the co-operation of the Carlisle City Council, a number of places have been made available at their new Adult Training Centre at Kingstown, Carlisle. A survey of the demand for this service in East Cumberland indicates that the number of places offered by Carlisle City Council will meet the needs of those trainees living within daily transport distance of Carlisle. Those who live in the more remote areas, however, will not be served until hostel provision linked with an adult training centre is provided.

A youth club known as the Parent Teacher Youth Club for mentally subnormals was started at the County Council Social Centre, Flatt Walks, Whitehaven during 1968. This has been a successful venture. There are about thirty members and an average of twenty-four attend the fortnightly evening meeting. The necessary transport is provided by a local industrial firm and the club is run by youngsters from the local grammar school.

A play group is also organised for the children from the Hensingham Junior Training Centre during the centre holiday periods. This group is run by the mothers and this is also held at the Social Centre, Whitehaven. They usually meet on two afternoons each week of the holidays and an average of six children attend.

Mental Health Hostel Accommodation

(a) For the Mentally Subnormal

The Orton Park Hostel for mentally subnormal children was opened in 1959 to accommodate children from remote areas of the county to enable them to attend the Wigton Junior Training Centre. The children are accommodated from Monday until Friday evenings during term. The premises which are adapted provide accommodation for 22 children. Twenty children were on the register at the beginning of the year, but by the year end 21 were regularly accommodated. The children come from all the outlying areas of the county, from Millom in the south to Gilsland and Penrith in the north.

One problem during the year resulted from the fact that 6 residents were 15 years old or over. This problem will not repeat itself for some time, as arrangements were made for these children to be transferred to Adult Training Centres by the beginning of January, 1969. The oldest child remaining in the hostel will then only be 12 years of age.

As a result of the trend during 1967 for a much younger age group to be accommodated an additional attendant was appointed in May, 1968. The care staff now consists of the matron and 4 part-time female attendants.

A party of 20 children and 4 staff from Pointfield Junior Hostel, Lancaster, Lancashire, were accommodated at Orton Park for a week during August whilst our children were on holiday.

It is still Council policy that this hostel will be replaced by smaller "family-unit" type homes during the 1971/76 period.

(b) For the Mentally Ill

“Fairview” the purpose-built hostel at Bransty, Whitehaven, was opened on the 8th February, 1966. When this hostel was being planned there were few similar hostels in the country. It was difficult, therefore, to gauge the need for such a provision in Cumberland. Because of this relatively unknown demand the hostel was built to accommodate 17 residents but designed in such a way that it could, if necessary, be easily extended to accommodate a further 13 residents.

The aim of this hostel is to provide:—

1. A halfway house to accommodate temporarily residents recovering from a mental illness involving hospitalisation, in a secure yet unstructured environment where they can adjust and respond to the needs and demands of the community before returning to that community.
2. Temporary accommodation at times of social crisis for persons in the community who have suffered or are suffering from a mental illness which does not warrant hospitalisation.

The following tables give statistical data on “Fairview”:—

Admissions					1966	1967	1968
From Garlands Hospital	...	...	...	...	15	5	16
From West Cumberland Hospital			...	...	2	4	4
From Dovenby Hospital	...	...	...	...	—	—	2
From Cockermouth Cottage Hospital	...			...	—	—	1
From community	...	...	...	...	12	8	7
Re-admissions from residential employment					—	2	6
TOTALS					29	19	36

Discharges					1966	1967	1968
To residential employment	...	...	...	...	4	5	10
To community	...	...	...	...	5	12	15
To hospitals	...	...	...	...	6	5	6
Absconded	...	...	...	...	—	2	—
TOTALS					15	24	31

					1966	1967	1968
Average occupancy	...	...	...	...	42.7 %	59.6 %	71.2 %

		In residence		In residence	
Diagnosis		at 1.1.68	Admitted	Discharged	at 31.12.68
Schizophrenia	...	8	21	21	8
Subnormality	...	—	7	4	3
Epilepsy	...	—	4	3	1
Depression	...	1	2	2	1
Alcoholism	...	—	2	1	1
TOTALS		9	36	31	14

The success of this hostel in terms of numbers rehabilitated to a normal community life has been encouraging but this has been marred by its persistent underoccupancy.

I first reported to the Mental Health Sub-Committee on the 26th May, 1961, the difficulties experienced by other authorities in establishing and maintaining short-term hostels for post-psychotics. Because I was not entirely satisfied with the forecast of the potential demand for this type of provision the Health Committee then accepted my advice to reduce the number of places in the hostel from the 30 originally planned to 17. In spite of this reduction, as the above tables show, the average occupancy in this the third year of the hostel was only 71.2%. This degree of occupancy has only been achieved as a result of intensive and continuing pressures by this department on all those from whom referrals for this type of care could reasonably be expected.

Of the 84 admissions since the hostel opened 51 have been discharged back to the community. Of those 32 have been able

to return to their home, relatives or lodgings, and the other 19 have been discharged to residential employment. The average stay before discharge to home or lodgings was 58 days and to residential employment 76 days. The residents who were discharged back to hospital, however, had an average stay in the hospital of only 22 days.

On the 31st December, 1968, of the 14 residents there were 4 who had lived in the hostel for over a year. The tendency for some to become long stay residents is being closely watched.

The hostel was without a warden from June, 1967 until April, 1968, when Mr. E. McKinney, R.M.N.; S.R.N., took up his appointment. The Assistant Warden, Mrs. Hinde, resigned on the 11th May, 1968. Mrs. Horne, S.E.N., took up the appointment of assistant warden on the 12th August, 1968. It was due to the efforts of Mr. McKinney and Mrs. Horne that employment was found for 15 of the residents during 1968. A further 7 residents found employment either as a result of their own efforts or those of the Department of Employment and Producticity. These figures are gratifying in view of the high incidence of unemployment in the West Cumberland area.

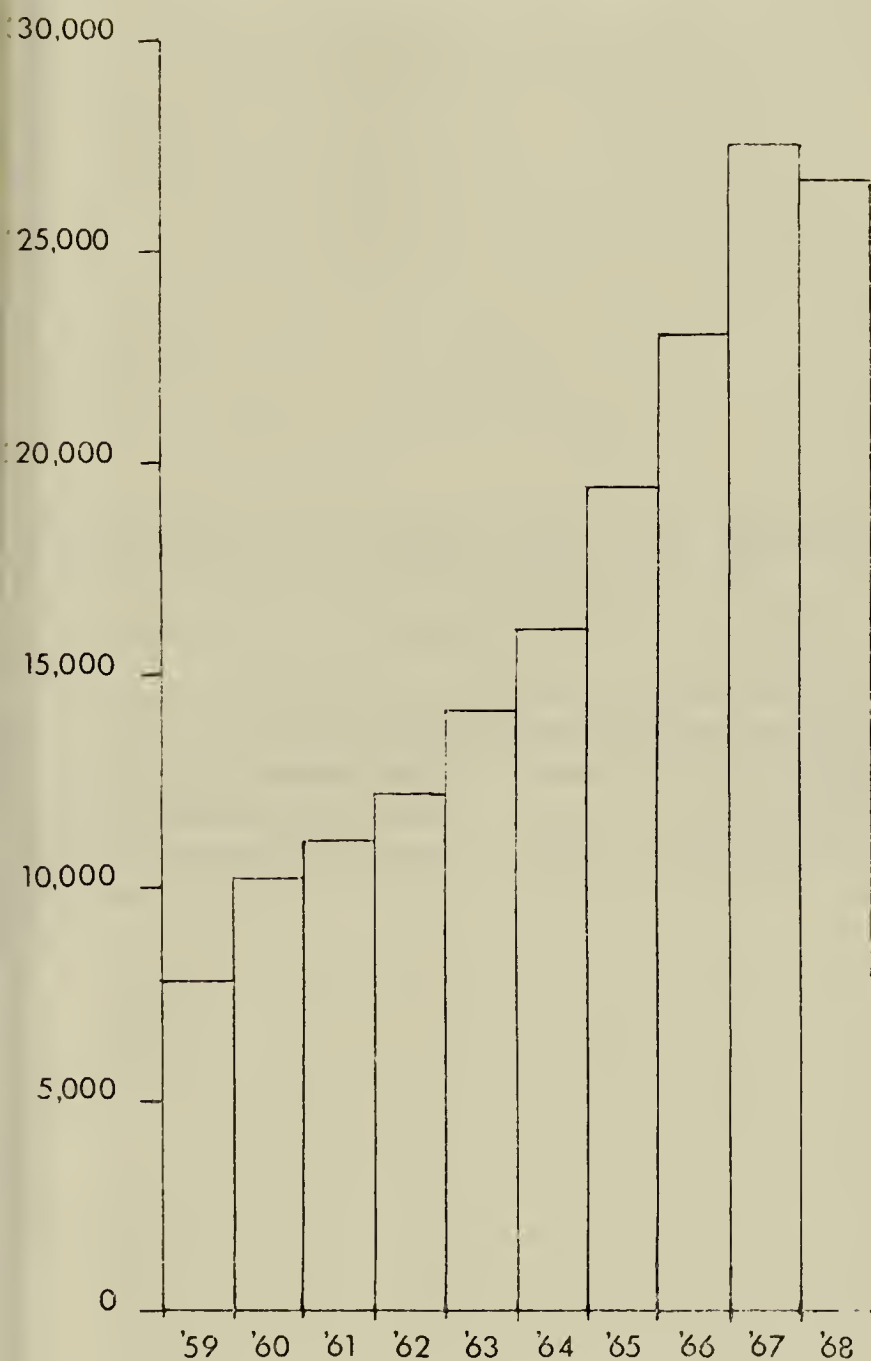
It will be seen from the preceding tables that residents who have suffered from schizophrenia have been in the majority. They have benefited very much from the unrestricted type of life which is encouraged at "Fairview". They are gradually absorbed into the "family" at "Fairview" and by group discussions they are helped to allay the anxieties resulting from the dramatic change from long-term hospitalisation to hostel life.

The residents admitted from the community have been discharged after an average stay of 44 days.

All are encouraged to attend a club for post-psychotic patients which meets each Wednesday evening from 7.0 p.m. to 9.30 p.m. at Flatt Walks, Whitehaven.

The Health (General Purposes) Sub-Committee at their meeting on the 10th December, 1968, considered the future of this hostel when it was resolved that the position would be reviewed in 12 months, and in the meantime the possibility of linking the service with voluntary effort in the same field would be explored.

TRAINING CENTRE ATTENDANCES



AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

"It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or expectant or nursing mothers from places in their area to places in or outside their area."

COUNTY AMBULANCE SERVICE

There has been a continued increase in the use of the service during the year under review; the number of patients carried has increased from 118,367 to 124,823 (6%) while the mileage has increased from 1,192,339 to 1,220,420. While still representing an absolute increase on the previous year, these figures show a lower rate of increase than has been the experience in recent years. When, however, it is considered that a large part of the increase is accounted for by geriatric cases for whom transport demands can only increase with extension of day care arrangements in hospitals and homes, it would be imprudent to forecast accurately the speed of increase in annual mileage and cases carried. It is pleasing to note, however, that the percentage increase in mileage has been appreciably less than the increase in patients and this is no doubt due to the constant efforts of the ambulance control staff and the continued close liaison between hospital and ambulance staff regarding the pre-planning of out-patient journeys, although there is still room for improvement in certain out-patient departments.

The out-of-county mileage has now reached 206,000 miles, an increase of 10,000 miles over last year. Half of this increase is accounted for by the conveyance of patients to the Limb Fitting Centre at Newcastle. It will be remembered that over eighteen months ago the County Council expressed concern over the difficulties involved in conveying patients to and from this centre and it was hoped that by now some provision would have been made for limb fitting in the county on a sessional basis. The present position is that the Special Area Committee hope to be able to establish an Artificial Limb and Appliance Centre in the county during the latter half of 1969 providing satisfactory financial arrangements can be made. There is no doubt that such a centre would be of great value to the patients who now have to make long and arduous journeys to Newcastle, besides materially reducing transport costs.

A substantial amount of transport in connection with the care of the elderly is being provided for the welfare services and the present position is such that any further increase will require consideration to be given to an increase in both men and vehicles.

to meet this commitment. There is, of course, much to be said for these patients being handled by trained ambulance personnel and the indications are towards the increased involvement of the ambulance service in this work and the sharing of costs.

304 home accidents to which ambulances are called out were reported to the Area Medical Officer concerned for investigation. This is a slight increase over the previous year, nearly half of them being accounted for by falls in the home, an increase of 4% over last year. The percentage of poisoning cases from "over-doses" remained the same but there was a drop from 12% to 10% of scalds and burns.

During the year it was necessary to arrange four helicopter journeys, all from the West Cumberland Hospital, to Newcastle General Hospital (1), Royal Victoria Infirmary, Newcastle (1), and the Lodge Moor Hospital, Sheffield (2), at a total cost of £597. Although there has been a small reduction in the rates for this form of transport this will be more than outweighed if the decision to close the R.A.F. Station, Acklington, where the helicopters are based, is proceeded with, as it is probable that machines from the more distant airfield at Leconfield will have to be used.

During the year there were two births in ambulances; both were satisfactorily dealt with.

Although only a relatively small part of the total volume of work carried out by the ambulance service, the emergency management of the victims of severe injuries will always be an important criterion of success and efficiency. I was very proud, on behalf of the ambulance service, to receive the following account of his recent experience from a well known member of the Penrith community who has wide experience himself of first-aid work.

"On Tuesday, 31st December, 1968, I had the misfortune to fracture both my legs in the vicinity of the ankles. This happened at about 4.45 p.m. some four miles south of Penrith on the A.6. Information was passed to my doctor by telephone and, within a very short time an ambulance from Penrith arrived on the scene in charge of the Ambulance Station Officer.

"Very efficiently my legs were immobilised by using inflatable splints, I was placed carefully on to the stretcher and put into the ambulance. Although the doctor had initially suggested my going to the Penrith Cottage Hospital, he readily accepted the Ambulance Station Officer's decision on the spot that I should be taken direct to the Accident Unit at Carlisle. For this consideration I was very pleased because from my own knowledge of such injuries I realised that I would have to go to Carlisle.

"The journey to Carlisle, in spite of my injuries, could not have been more comfortable and every consideration was given to my well-being, and on my arrival at the Cumberland Infirmary I felt none the worse for the journey.

"Although it was confirmed that I had fractured both legs I was not admitted and after having both legs put in plaster I was informed that arrangements had been made for me to be taken home.

"The return journey to Penrith was undertaken by ambulance and crew from the County Ambulance Station at Carlisle. The journey was most comfortable and once again every consideration was given to me by the crew, not only enroute but on arrival at my home where I had to be carried into the house and into bed.

"I am very pleased indeed that I have been given the opportunity to place on record the admirable way that the County Ambulance crews looked after me when I was in need. The vehicles used could not have been more comfortable and the attendants were most attentive to my welfare and comforts."

The writer is able to comment with some authority in this connection as he has had a vast amount of experience with regard to instruction in First Aid generally and casualty handling.

In this connection there is further comment below by the Station Officer from Penrith on successful co-operation and integration with the staff of the Casualty Department of the Cumberland Infirmary. I am grateful to Sister Walker at the Casualty Department for the following comments:—

"The service is an excellent one, and has benefited from the time spent by the ambulance personnel in the Casualty Department.

"This has been shown by an improvement in 'communication', observation and general care and attention to the patient, and the interest taken by the men in the diagnosis and the result of treatment; with the desire to improve the service which they give to patients."

Developments

The newly-formed Management Services Unit of the County Council has been asked to conduct a comprehensive survey of the ambulance service and it is hoped this will start early in the New Year.

Experience has confirmed the usefulness of having radio in general practitioners' and nurses' cars linked to the ambulance service frequency. Doctors are able to contact the ambulance control direct from a remote rural patient's home in order to arrange transport, while midwives have been able to contact a doctor through the ambulance control in those cases which required his attendance, or about which advice was required. There is no doubt that the family health care team in the area regard the radio communication service linked to the ambulance network as an essential and important feature of their work. There are now twelve midwives with radio equipped cars.

A very interesting picture of developments in the local situation is given below by Mr. Corry, the Station Officer at Penrith, where, during 1968, the staff have had the first experience of motorway cover. Mr. Corry writes:—

"The Ambulance Service in the Penrith area during the past year has seen changes in its operation as follows.

"The local doctors have been given facilities which enable them to speak direct to the ambulance personnel when requesting ambulance transport at any time during the day or night. This enables the doctor to give exact, and often vital, information regarding a patient and also enables the control

staff to establish the urgency of the journey. This I feel is a big improvement on the system of the police relaying messages from doctors to the ambulance control.

“The service is working more closely than ever with the welfare department, notifying them whenever a health visitor or nurse appears to be required by some person in need of care.

“During the year we have become almost a part of the accident department of the Cumberland Infirmary and I was delighted to hear the ambulance service referred to by the head of that department as ‘the third arm of the casualty officer’ and on another occasion as ‘mobile accident clinics’. This is indeed ‘a feather in our cap’ and we should be proud that at last we are outliving the old conception of an ‘ambulance driver’.

“Our yearly training at the Cumberland Infirmary continues, members of the staff serving a week in the accident department. This year a session of questions and answers was arranged which proved to be popular as it involved class participation.

“The M6 (Penrith Bypass) was opened during 1968 and this involved the training of ambulance crews in the procedure to adopt when attending a motorway incident. During the training period it was brought home to all concerned just how dangerous it is for untrained persons to attend these incidents. Contrary to expectations there have not been any accidents with injury on this section of the M6 to date.

“Our day to day work continues to increase and at this point I would like to thank the hospital car service operators, who have given their time and services during the past year. The Voluntary Aid Societies have undertaken duties at the station, putting into practice the things they have learned in the classroom. This practical experience will serve them well if they are ever needed in moments of crisis.

“During the past year 199 members of the public, representing various organisations, have visited and been shown round the ambulance station. In addition to this outside visits have been made by myself to other groups explaining and talking about the ambulance service.”

Arising from the development of group practices throughout the county and the establishment of treatment facilities at practice centres, transport is now being provided to take carefully selected patients to practices operating in rural areas with a scattered population. No problems have arisen but there are severe restrictions on the extent of such a service, having regard particularly to cost.

The Officer in Charge of the Millom Station comments:—

“During the twelve months under review, there has been an improvement in the service in this area, due to the development of the group practice. Since this began, we have found that surgery patients account for approximately 14% of all patients carried. As 50% of these would, at one time, have been treated at hospital (a minimum of 30 miles away) thereby necessitating much additional transport, there has been a considerable economy in ambulance mileage over the twelve months. It is particularly gratifying to be able to report that, since its inception, we have been given every assistance from all concerned with the group practice, which has contributed in no small measure to the smooth running of this part of the service.”

Owing to the increase in the amount of work done from the Millom Ambulance Station the staffing position gave cause for concern, as on occasions it was necessary for the Officer in Charge himself to leave the station to drive an ambulance. It was, therefore, necessary to call in help in telephone manning. The person concerned, who had had previous ambulance control work, is to be paid an honorarium for the work he does.

Stations.

The site for the purchase of land at the rear of the Cumberland Infirmary, Carlisle, for the building of the new Carlisle Station to replace the present premises at Bush Brow is still being negotia-

ted. The Department of Health and Social Security has approved the Council's cost limit of £50,215 for this work and it is hoped that it will be possible to include the work in the 1969/70 building programme. The provision of this station is something to which the staff have been looking forward for a very long time and it says a great deal for them that such poor working conditions has not impaired the standard of their work.

The same is also true of Millom where the lease for the present station expired on 30th September. As the building of a new station there does not have a place in the capital building programme until the financial year 1971/72 it was necessary to renew the lease for a further five years. The terms and conditions of tenancy remain unchanged.

Vehicles

During the year orders were placed for one traditional Bedford/Lomas ambulance and two dual purpose vehicles. These vehicles were for normal replacement at Distington Station and Bush Brow Station, Carlisle.

Training

Drivers in West Cumberland have commenced the one week's in-hospital training programme at the West Cumberland Hospital, Hensingham, which it had been necessary to suspend temporarily because of the holiday period. Arrangements are also in hand for new entrants to the service in East Cumberland to receive this training at the Cumberland Infirmary, Carlisle. I am greatly indebted to the hospital consultants and other staff who undertake the training and to the Hospital Management Committee for putting these facilities at our disposal.

The first Annual County First Aid Competition was held in May at the Distington Engineering Company's premises in Workington and was won by the team from Millom. This team later won the North Regional Ambulance Competition held in Morpeth and went on to represent the Region in the National Finals held in Solihull in August. Although they were not successful in the National Finals the team put up a very good performance and when it is remembered that they were competing against teams

from authorities where direct services had been operating for considerably longer, it will be appreciated that their achievement was one of which all concerned can justly be proud. That such a standard has been established in such a short time is due to the enthusiastic approach of all personnel to their job and also to the help received from the hospital departments and general medical practitioners.

Hospital Car Service

Once again the 116 members of the Hospital Car Service have done an enormous amount of work on behalf of the ambulance service, covering this year approximately 600,000 miles. There is no doubt that this service, which comprises the voluntary component of the ambulance service, is very worthwhile and much appreciated by all patients. I am most grateful to all those drivers who continue to give such devoted service.

Mrs. Lee, Branch Director of the British Red Cross Society, writes as follows:—

“1968 has been another very busy year for the members of the Hospital Car Service. They have dealt with just over 46,000 patients and covered 626,000 miles, an increase on last year's work.

“There have been very few resignations and those that have occurred have been for personal reasons only and not through any disillusionment with the service. From my own observations all members continue to be very enthusiastic about their work and I am most grateful to them for their continued dedication.”

Mr. McGarry, Officer in Charge, Millom, comments:—

“The Hospital Car Service continues to play a big part in day to day operations. Indeed, it is no exaggeration to say that, without the help of the operators concerned, it would be impossible to operate an efficient service in this area without a large expansion of staff and vehicles.”

The following comments of two Hospital Car Service drivers are also very interesting.

Mrs. Williamson from Silloth writes:—

“I find the work most enjoyable and I feel that there are many patients who appear to prefer travelling by a private car than in an ambulance. Most patients are very appreciative of the car service.

“Occasionally waiting time seems to be excessive and it can be difficult when a patient insists on being accompanied by an escort when one hasn't been requested. The older patients seem to feel they need an escort.

“I find that the Hospital Car Service enables me to get out and meet people and I feel that I am doing a worthwhile job.”

Mrs. Bodecott from Cockermouth comments:—

“Having been blessed with good health myself I find the experience most humbling as, day by day, I see the sick being carried to and from the hospitals.

“The chronic sick, by their display of courage, are both humbling and challenging.

“Apart from the occasional ‘take it all for granted’ type, I find that most people are really appreciative of this service and often voice their feelings to this effect.

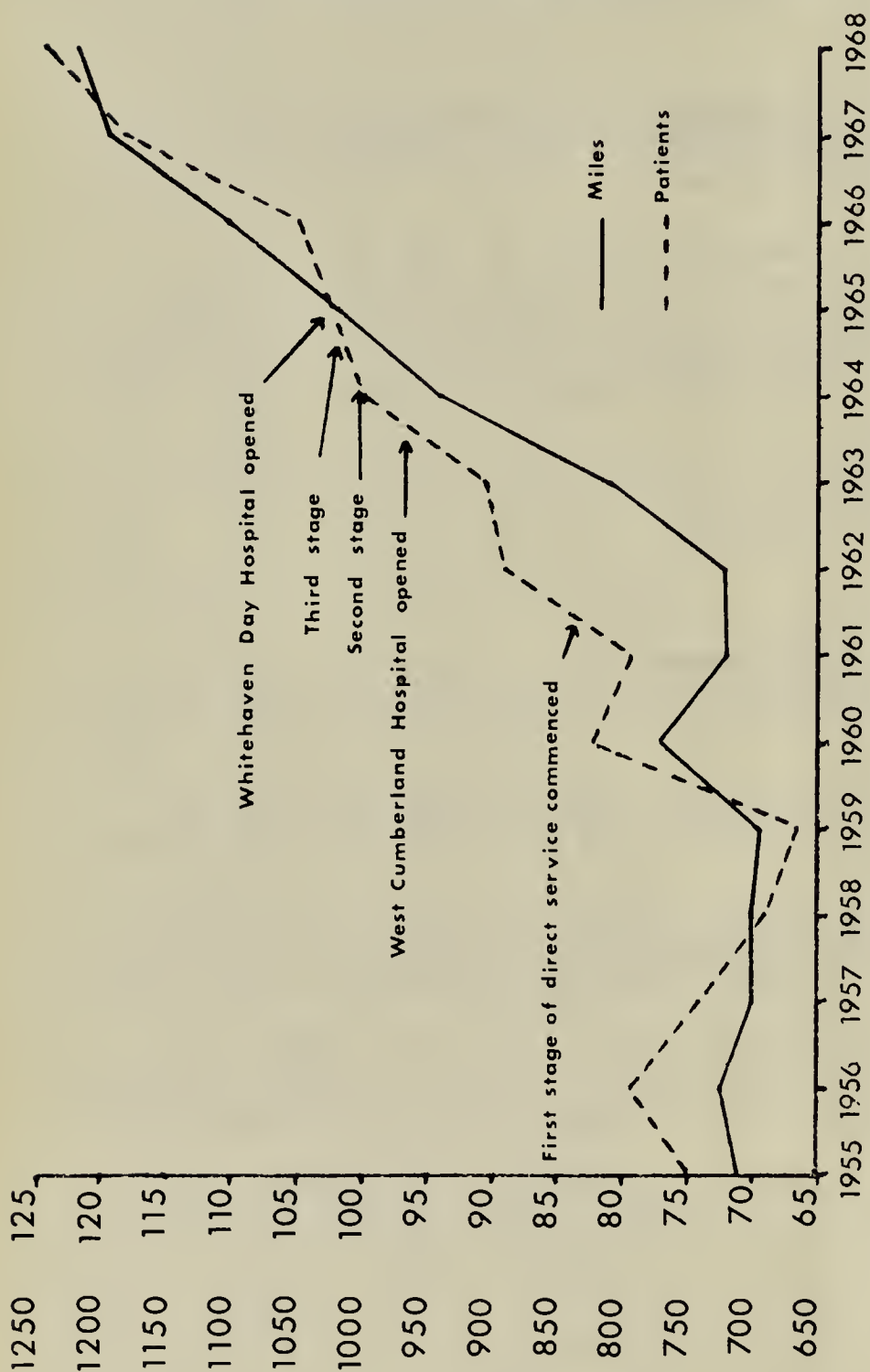
“There is quite a good co-operative spirit among the patients and the old saying ‘United we stand but divided we fall’ is most applicable in this unusual context !

“The ambulance staff are most courteous and helpful at all times, thus making it a pleasure to serve.”

Ambulances Sitting-Case Cars Hospital Car Service Summary of all Services

		Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage	Total number of patients carried	Total Mileage
1967	Agency Service ...	608	15783	3858	30338	1196	32110	5662	78231
	Direct Service ...	70427	545641	—	—	42278	568467	112705	1114108
	TOTAL ...	71035	561424	3858	30338	43474	600577	118367	1192339
1968	Agency Service ...	912	13789	4073	29712	1303	35130	6288	78631
	Direct Service ...	73429	550598	—	—	45106	591191	118535	1141789
	TOTAL ...	74341	564387	4073	29712	46409	626321	124823	1220420
Increase or decrease compared									
	with 1967 ...	+ 3306	+ 2963	+ 215	—626	+ 2935	+ 25744	+ 6456	+ 28081

CUMBERLAND—GROWTH IN THE USE OF THE AMBULANCE SERVICE



GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing

INFECTIOUS DISEASES

The table of notifications of infectious diseases for 1968 is shown on page .

The most striking change during 1968 in the notification of infectious diseases concerned measles. It will be seen that the total of notifications in 1968 is the lowest for several years and this is rather dramatically shown on the graph on page 132. There the biennial peak of measles incidence is clearly indicated occurring in 1965 and in 1967 in both cases in the early part of the year. The last part of the graph, however, shows the notifications for the early part of 1969 up to the time of writing this report. The absence of a peak at this point is striking evidence of the effect of the measles vaccination campaign begun in 1968 and now continuing for all young children. The relatively low number of measles notifications in 1968 also reflects the beginning of this decline in measles and so we witness the waning of the last of the notifiable infectious diseases to produce large figures each year.

A slightly disturbing feature of the notifications table, however, is the recurrent appearance of substantial figures of dysentery. This was the highest in 1968 ever recorded and it should be remembered that this by no means represents the total incidence of this infection. The control of dysentery and other gastro-intestinal infections is not by mass community immunisation programmes, but by vigorous personal and food hygiene. It is not insignificant that in 1968 two cases of typhoid fever were notified, and although these cases remained unexplained in spite of investigation, and no spread took place from them, the necessity is underlined of continuous vigilance in the matter of a high standard of hygiene. In this connection I am glad that a little progress appears to have been made during 1968 towards providing hygienic public conveniences in certain key spots in the Lake District. The administrative complexities of this matter and the financial problems involved are, however, very frustrating when the hazards of serious infectious diseases are so clearly apparent.

Infective jaundice became a notifiable disease for the first time on 15th June, 1968, this should facilitate the epidemiological study of this condition whose spread may very well also hinge upon personal hygiene, particularly hand hygiene after the use of toilets. It will be apparent how this matter becomes more important in the control of infectious diseases as vaccinations and immunisations come to increasingly control those infections which are more usually associated with the "coughs and sneezes" type of spread.

NOTIFICATION OF CASES OF INFECTIOUS AND OTHER NOTIFIABLE DISEASES 1968

	Scarlet Fever	Whooping Cough	Potiomyelitis	Measles	Dysentery	Meningococcal Infection	Acute Pneumonia	Acute Encephalitis Infective	Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Erysipelas	Food Poisoning	Tuberculosis Respiratory	Meninges and C.N.S.	Other T.B.	Puerperal Pyrexia	Ophthalmia Neonatorum	Infective Jaundice
URBAN DISTRICTS—																			
Workington	2	1	—	291	7	1	—	—	—	1	—	—	—	10	—	—	1	—	2
Whitehaven	9	1	—	9	3	2	7	—	—	1	—	—	—	7	1	3	—	—	14
Cockermouth	—	—	—	65	203	—	—	—	—	—	—	—	—	2	—	—	—	—	—
Keswick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Maryport	11	—	—	37	—	—	5	—	—	—	—	—	—	2	—	—	—	—	—
Penrith	2	1	—	11	14	—	—	—	—	—	—	—	—	1	—	—	—	—	6
RURAL DISTRICTS—																			
Alston	1	—	—	33	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	6	8	—	46	15	—	—	—	—	—	1	1	2	1	—	2	—	—	4
Cockermouth	2	—	—	80	33	1	—	—	—	—	—	1	—	7	—	1	—	—	3
Ennerdale	6	—	—	18	9	1	2	—	—	—	—	—	—	3	—	4	1	—	10
Millom	7	36	—	18	1	—	—	—	—	—	—	1	—	4	—	—	—	—	1
Penrith	—	—	—	10	6	—	—	—	—	—	1	—	—	1	—	—	—	—	4
Wigton	9	4	—	124	12	—	—	—	—	—	—	1	—	1	—	—	—	—	2
TOTAL FOR YEAR	55	51	—	742	303	5	14	—	—	2	2	4	2	39	1	10	2	—	46
1967	60	76	—	2204	37	1	9	—	—	—	—	7	2	46	—	11	11	—	—
1966	184	83	—	1183	14	1	49	—	—	1	—	4	4	54	—	13	33	—	—
1965	76	17	—	3480	261	—	9	—	—	—	31	7	10	56	2	10	7	—	—
1964	119	152	—	1064	12	—	16	—	—	—	1	4	4	73	2	13	2	2	—
1963	23	119	1	1836	50	5	22	—	—	1	—	4	31	76	1	12	12	—	—
1962	35	39	2	2485	149	6	40	—	1	—	—	4	40	94	1	12	33	—	—

Food and Drugs Act, 1955

Summary of work done under the above Act during the year ended 31st December, 1968

Total Samples Obtained		Genuine		Unsatisfactory	
Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
582	219	536	215	46	4
801		751		50	

During the year 801 samples were obtained of which 582 were milk and 219 various foods and drugs; the latter, plus 54 milk samples, were submitted to the Public Analyst and the remainder of the milk samples were tested by the Sampling Officers.

In addition to the ordinary compositional analysis, a number of the milk samples submitted to the Analyst were also tested for antibiotics but none were detected.

The average quality of the milk samples tested by the Sampling Officers, including 24 below standard, was 3.67% fat and 8.65% solids-not-fat compared to the presumptive standard of 3.0% and 8.5% respectively.

The percentage of unsatisfactory samples, of the total number obtained, was 6.2% compared to 2.8% the previous year. Taken separately the unsatisfactory milk samples increased from 3.2% to 4.5% and the percentage of unsatisfactory articles other than milk decreased from 2.1% to 1.8%. The increased percentage in unsatisfactory milk samples does not necessarily mean a rise in the number of farmers producing poor quality milk; it must be borne in mind, especially where added water is suspected, that as many as ten samples are sometimes taken from the total milk yield of one producer in which circumstances that producer could be responsible for ten adulterated samples. The percentage of unsatisfactory milk samples could thus show an increase when, in fact, the number of producers might have decreased.

Unsatisfactory samples were dealt with as follows:—

Milk:

Of the 46 unsatisfactory milk samples, 22 were submitted to the Analyst.

Four were below standard in non-fatty solids but the deficiencies were not due to added water. The attention of the producers concerned was drawn to the poor quality and further samples taken later were satisfactory.

One sample, deficient in non-fatty solids, was too sour to apply the freezing point test which is necessary to determine the presence of extraneous water. However, a further sample was obtained and this was satisfactory.

Two samples of bottled milk containing added water to the extent of 35.3% and 30.6% were from milk being sold on a retail round; other samples of milk from the same source and consigned to the Milk Marketing Board and "appeal to cow" samples were genuine. The producer/retailer was prosecuted and fined £15 on each of two charges plus total costs of £21 8s. 0d. This offence came to light because a customer, doubtful of the quality of the milk supplied to her, notified the sampling officer of her suspicions which turned out to be well founded.

From a consignment of milk which a farmer sent to the M.M.B. ten samples were taken, one was genuine but nine contained added water in amounts ranging from 2.3% to 15.1%. Proceedings were instituted against the producer and at his request application was made for an adjournment. Unfortunately the case was called on the date originally fixed for the hearing when neither of the parties concerned were in Court and the information was dismissed. The Magistrates' Clerk stated that he had not received the letter requesting the adjournment.

Following upon tests of three informal samples which had been taken at a dairy, ten formal samples were taken at the farm where the milk was produced and five of them contained added water in amounts ranging from 9.0% to 35.9%. The producer,

unable to account for this added water, requested the Police to investigate the matter. A cowman, who had been in the employ of the producer up to and including the time the samples were taken admitted adding water to the milk "to keep up the average yield". The cowman was prosecuted and fined £20.

The 24 samples which were found below standard by the Sampling Officers comprised 20 which were low in non-fatty solids, 1 deficient in fat and 3 which contained added water. Freezing point tests on the first 20 indicated that the deficiencies were not due to added water and samples taken later from the same sources of supply were satisfactory. For the one which was deficient in fat a further sample was taken which proved satisfactory. The 3 containing added water have been referred to in the previous paragraph.

Unsatisfactory items other than milk:

The labels on two articles of food, jam and concentrated orange squash, infringed the labelling requirements and the attention of the manufacturers was drawn to the matter.

A sample of dried milk powder was taken, after a complaint from a school kitchen, because the powder contained some black deposit. It appeared that the black spots, which were found in the milk when reconstituted as a liquid, were ammonium and iron citrate, an additive to dried milk. A further complaint concerned a loaf of sliced bread which appeared to have mouse excreta between two slices but the Analyst found the substance to be charred carbohydrate. No further action was taken in either case.

Pesticide residues in foodstuffs:

The national scheme for the testing of foodstuffs for residues of insecticides and pesticides concluded during the year and the last samples submitted by this authority for analysis were milk, eggs, bacon and beef but all tests were negative.

This was a scheme covering a period of two years whereby participating Food and Drugs Authorities undertook a systematic survey covering England and Wales. The principal objective was to find the extent, if any, to which foodstuffs in common use were

being contaminated and, if so, to obtain a reliable indication of the levels of such contamination. A report has now been issued covering the first year's working of the scheme and the following is an extract:—

“The results for the first year indicate that there is no evidence of contamination sufficiently serious to be of significance to public health in the short term. None of the samples revealed gross contamination. In setting up the scheme the Association had in mind the possibility of samples being contaminated sufficiently to justify follow-up enquiries regarding specific batches or sources of food. In fact, only one or two of the samples analysed have been found to indicate the need for special action of this kind. On the other hand, a large proportion of the samples examined contained traces of pesticides and in such samples the amounts, though too small to attract any doubt as to the fitness of the food for human consumption, were sometimes larger than had been expected for that particular pesticide or for that particular kind of food. The results of surveys in subsequent years will be of great interest and should do much to reveal any definite trend.

One of the properties of the ideal pesticide is that it should leave no detectable residue. This condition, however, is seldom achieved in practice and it is for this reason that a number of countries, including the U.S.A., lay down maximum limits which any residue present should not exceed. It should be borne in mind that tolerated amounts are many times less than the minimum quantity which is required to give rise to acute poisoning. With the exception of lead and arsenic residues, limiting quantities are not generally prescribed in the U.K. The Food Additives and Contaminants Committee of the Ministry of Agriculture, Fisheries and Food recommended in 1966, that limits should be prescribed for aldrin and dieldrin in foods, but as yet no Regulations have been made as a result of this recommendation. Although low levels of pesticide residues were found in a substantial proportion of the samples examined in the survey, nevertheless these were, in most cases, below the statutory limits for residues which have been laid down in other countries.”

L. WHARTON,

Chief Inspector of Weights and Measures

Housing, Water Supplies, Sewerage Schemes and Caravan Sites

This year I am including comments from certain of the District Medical Officers of Health who have kindly given me information on environmental conditions and plans for their districts. The districts concerned are the Border, Millom and Penrith Rural Districts, Penrith Urban District and the Workington Municipal Borough.

I have combined these comments with the usual annual data on Housing, Rural Water Supplies and Sewerage provided by the Clerk of the County Council.

Housing

In the Border Rural District one hundred and three families were housed during the year and forty-two families transferred to accommodation more suitable to their needs.

There are a number of houses in Workington Borough which are old terraced dwellings of which some are still substantial but becoming substandard and lacking in amenities. An area of such buildings was designated an Improvement Area, the first in the county and the Corporation purchased one of the houses in this area and brought it up to a good standard of repair and amenity as a "Show House".

In Penrith Urban District there are ninety families still occupying unfit dwellings and these are included in the two hundred and seventy-eight families requiring council house accommodation.

The number of overcrowded dwellings in Millom Rural District increased from six to eight during 1968 and the number of people affected by this increased from forty-four to sixty-two.

During 1968 one hundred and thirteen units of accommodation were built for Wigton Rural District Council, comprising forty-three houses and seventy bungalows. Six houses were allocated to "key workers" in industry. The Council is very much alive to the need to encourage new industries and has been helpful in this respect in view of the industrial development taking place at Silloth Airfield.

Water Supplies

Apart from the Penrith and Central Area Water Scheme submitted by the Eden Water Board and estimated to cost £24,500, all the remaining seven water supply schemes submitted for observations in 1968 were small mains extension schemes costing in the region of £1,500. (Details of each scheme are set out in the following schedule). This is a very similar position to 1967 and 1966.

The whole of the Penrith Urban District is supplied with water by the Eden Water Board. During the year twenty water samples were taken and were classified as excellent. The water supplies in the Millom Rural District area are all chlorinated and of the one hundred and forty-seven samples taken five were found to be unsatisfactory.

Grants

Notification of Ministry grant in respect of four sections of the Carlisle Corporation Major Capital Expenditure Programme—a total of £2,087 per half year for thirty years—together with eight lump sum grants in respect of small schemes was received during the year and the County Council matched the grants in all cases.

Sewerage Schemes

Five new sewerage schemes were submitted during the year, three from Penrith and one each from the Border and Wigton Rural District Councils—details are set out on the following schedule.

The sewerage works for Penrith Urban District are now in need of further overhaul and modernisation, since the works were last modernised in the mid 1930's the number of houses has risen by one thousand, all having baths, water closets, etc.

During the year Millom Rural District Council had a comprehensive specialist survey on the sewerage arrangements serving both Millom and Haverigg carried out. A report on the findings is expected soon.

Grants

Notification of Ministry grant in respect of three sewerage schemes was received during the year as follows:—

Border	Heads Nook Scheme	Lump sum £2,993
Border	Walton Sewerage Scheme	Lump sum £2,587
Border	Newtown and Irthington Sewerage Scheme	£246 a half year for 30 years

The County Council made equivalent grants in all cases.

General

Approval by the Ministry of Housing and Local Government of schemes of sewerage and sewage disposal is still subject to the condition that there is a risk to health. In some cases this is being interpreted more stringently and several schemes listed above are unlikely to be approved because the condition they are to cure, although offensive, is not adjacent to dwellings or public highways and therefore not considered a risk to health.

Caravan Sites

There are two caravan sites in the Penrith Urban District. One is licensed for residential caravans and the other for both residential and touring caravans.

There are twenty-seven licensed caravan and camping sites in the Penrith Rural District area, an increase of eight over the 1967 figures.

There are twelve licensed caravans in the Border Rural District of which three are purely for holiday and touring purposes.

In the Millom Rural District there are fourteen licensed caravan sites, nine are residential and five for holiday caravans.

APPENDICES

- I. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.**
- II. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.**
- III. County Council Clinics.**

APPENDIX I

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland by Dr. R. Hambridge.

During 1968 there has been very little change in the situation arrived at in 1967 so far as tuberculosis in West Cumberland is concerned. The Tuberculosis Register at the 31st December, 1968 was made up of the following numbers of cases:-

	Men	Women	Children	Total	
Respiratory T.B.	567	346	36	949	(1099)
Non Respiratory T.B.	28	29	6	63	(65)
Total	595	375	42	1012	(1164)

(Figures in brackets relate to comparable data for 1967).

Some 71 cases were removed from the Register, deemed recovered, during the year: and a further 20 cases died of various causes—only 3 of these from tuberculosis. The Register was augmented, however, by new cases diagnosed during the year: details of these are tabulated as follows:-

New Cases:

	Men	Women	Children	Total
Requiring observation only	31	12	3	46
Requiring treatment:				
(Respiratory)	20	9	3	32
Non-Respiratory forms)	5	5	1	11
Total	56	26	7	89

Of the 32 Respiratory type cases requiring treatment, 50% (16) were infectious at diagnosis. Although the number of new cases is appreciably less than a few years ago the proportion of them diagnosed before they have reached a frankly infectious form has fallen from around 75% to 50%. This tendency is likely to persist and make the removal of tuberculosis from the community highly improbable.

Amongst the existing Tuberculosis Register of 1,099 respiratory cases, at 31st December, 1967, a further 46 cases of reactivated disease arose of which 10 were infectious when so discovered.

Those patients who died during the year of tuberculosis were 3 in number: a 93 year old spinster diagnosed posthumously and a 38 year old spinster who refused treatment in Cumberland and died in Wales: and a 64 year old widower who died undoubtedly of tuberculosis but whose treatment had been totally inadequate because of epilepsy, neglect and dementia.

Examinations of Contacts.

The tracing of familiar and household contacts of new cases has, of course, continued: in the main only children and infants have been seen at out-patients, adults being referred to the Static 100 mm. X-ray Units at Workington Infirmary and the West Cumberland Hospital. All children under 15 years of age not already vaccinated with B.C.G. at school have been tuberculin tested (1/1000 O.T.) and non-reactors vaccinated. The figures for this programme have, this year, been made somewhat artificial by the inclusion of some 200 infants who were vocational contacts of a highly infectious nurse: but even so do indicate the low level of infection occurring amongst the youthful population of the area.

In the age group three months to 4 years old, one reactor infant was found in 243 tested. (No reactors were found from amongst the 202 vocational contacts of the nurse). From 5 to 9 years of age 2 reactors were found in 42 tested; and from 10 to 14 years old 1 reactor found in 22 tested. From the 4 reactor children 3 cases of notifiable tuberculosis were diagnosed.

A further 264 contacts—children over 15 and adults—are known to have passed through the Static M.M.R. Units and from this number 2 cases of disease (one notifiable) were found.

A total of 527 contacts previously known to the Chest Service were also seen and x-rayed during the year.

B.C.G. Vaccination.

A total of 318 infants and children, including new-borns were vaccinated with B.C.G. (397 in 1967).

Static Mass X-Ray (100 mm) Units.

Two units have operated during the year: in the first half of the year each unit was staffed by one general purpose worker responsible for the clerical and radiographic techniques, but following the transfer of responsibility of these units from the Regional Board to the Hospital Management Committee in the middle of the year staffing was reduced, making part-time operation of each unit obligatory. The sharp reduction in the total amount of work done and the usefulness of the units is evident in the annual figures and may well prompt consideration of the wisdom of laying out capital which is rendered useless by policies of "economy" in operation.

STATIC M.M.R. UNITS — 1968

WEST CUMBERLAND HOSPITAL

	No. of Miniature films taken	Number recalled for clinical examination	Active T.B.	Inactive T.B.	Neoplasms	Sarcoid	Acquired Cardiac Conditions	Pneumoconiosis without PMF
General Public	959	20	—	1	—	1	—	—
Doctors' Cases	999	62	1	2	5	1	2	1
Contact Cases	107	2	1	—	1	—	—	—
Outpatients	845	17	—	1	1	—	—	3
Firms	789	9	—	—	—	—	—	—
Scholars	62	1	—	1	—	—	—	—
TOTALS	3761	111	2	5	7	2	2	4

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WORKINGTON INFIRMARY

	No.	Number recalled for clinical examination	Active T.B.	Inactive T.B.	Neoplasms	Sarcoid	Acquired Cardiac Conditions	Pneumoconiosis without PMF
General Public	880	12	1	1	1	—	—	—
Doctors' Cases	1446	66	2	3	3	—	2	1
Contact Cases	157	5	—	1	—	—	—	—
Outpatients	85	3	—	—	—	—	—	—
Firms	285	2	—	—	—	—	—	—
Scholars	69	3	—	—	—	—	—	—
TOTALS	2922	91	3	5	4	—	2	1
TOTAL BOTH UNITS	6683	202	5	10	11	2	4	5
TOTAL 1967	8054	—	12	21	17	1	8	14
TOTAL 1966	8349	—	11	51	7	1	9	13

The number of referrals from General Practitioners in this area is rising annually—in 1966 2,191; 1967 2,357; and in 1968 2,445. The proportion of general practitioner referrals is, however, more striking, representing 26.2% in 1966; 27.8% in 1967; and 36.6% in 1968 of the total number of persons examined: and compares interestingly with the meagre 1% contribution of Workington Infirmary Outpatients routine scrutiny, the machinery for which rests also with the Hospital Management Committee.

Outpatient Clinics:

Sessions have continued at both Workington Infirmary and the West Cumberland Hospital at which 541 and 405 new patients were seen respectively. At each centre 1,172 and 1,156 old patients attended, giving a total of outpatient attendances for 1968 of 3,271.

Inpatients:

During the year there were 68 tuberculous admissions to Home-wood (52 men and 16 women); and 101 admissions of a variety of non-tuberculous conditions (83 men, 18 women) giving a total of 168 admissions. Of these 17 were transferred to Seaham Hall for thoracic surgery.

Pulmonary Neoplasm:

The number of these cases diagnosed by Mass X-ray (11) was less than in 1967 (17). However, a total of 34 cases were dealt with during the year—30 men and 4 women. The survival rate remains depressingly low, 12 of the 34 not surviving the year and no more than 4 patients being found suitable for successful surgical removal of the growth.

An increasing number of sufferers from a variety of conditions giving rise to pulmonary heart disease and respiratory insufficiency are attending Chest Outpatients. These now outnumber the annual incidence of pneumoconiotics in West Cumberland. With the closure of further haematite and coal mines in this area during the past year, the prevalence of industrial pulmonary disease remains only amongst the older generations of West Cumberland and, presumably, will increasingly be so. Nevertheless, with an ageing population the combination of infection and emphysema appears to be more common than a decade ago; and an appraisal of the size of this problem in the community now could well be regarded as a realistic initial step in public health.

APPENDIX II

**Annual Report on Tuberculosis and other chest diseases in
East Cumberland in 1968 by Dr. W. H. Morton**

Introduction

There has been a very gratifying decrease in both the number of new cases of pulmonary tuberculosis discovered during 1968 and in the number of new cases of bronchial carcinoma. The former have dropped from 38 in 1967 to 19 in 1968, and the latter from 76 in 1967 to 57 in 1968. These are the total figures covering the City of Carlisle, the Eastern Division of the County of Cumberland, and North Westmorland.

Tuberculosis

Table 1 shows the total number of new cases of pulmonary tuberculosis for England and Wales, and for the three areas of East Cumberland, the City of Carlisle, and North Westmorland for 1968 and the previous five years:—

Table 1

Year	England & Wales	East Cumberland	Carlisle City	North Westmorland
1963	16,355	18	19	—
1964	15,026	25	14	3
1965	13,552	14	20	—
1966	12,461	11	20	4
1967	11,029	23	13	2
1968	10,681	6	12	1

The number of chest beds available during 1968 with the number of patients discharged during 1967 and 1968 are shown in Table 2.

Table 2

Hospital	Beds available	No discharged in 1968	No. discharged in 1967
Ward 18,			
Cumberland Infirmary	13	239	263
Blencathra Hospital ...	11	29	43
Longtown Hospital ...	26	134	135

The number of notified cases of tuberculosis on the chest centre Register as at 31st December, 1968 totalled 371; the number of cases of tuberculosis, whether notified or not, under treatment, supervision, or observation, totalled 1,200. Of the 19 new cases of pulmonary tuberculosis discovered during 1968, 14 were found to have a positive broncho-pulmonary secretion.

The regimen of therapy remains much as it did before, but resistance to first and second line drugs have been a problem in two cases during the year. No cases of pulmonary tuberculosis have been submitted for surgery.

Contact examinations have continued as in previous years, and all contacts under the age of 21 have been Mantoux tested—747 having been done.

Table 3 gives the number of B.C.G. vaccinations carried out during the year:—

Table 3

	Male	Female	Total
Carlisle City	49	46	95
East Cumberland	70	88	158
North Westmorland	7	6	13
Hospital staffs	2	44	46
	128	184	312

Last year I mentioned some difficulties of Mantoux testing. When B.C.G. vaccination was first introduced in 1950 Mantoux testing was essentially part of the campaign. First, only negative reactors amongst contacts were given B.C.G. vaccination. It is still the practice to do Mantoux tests on all contacts and only negative reactors are given this vaccination. We used to follow up the B.C.G. vaccination with a further Mantoux test about six weeks later, and the vast majority of cases so vaccinated then gave a positive reaction. We also carried out Mantoux testing in all our contacts who had been vaccinated, at five-yearly intervals, and in the past we have re-vaccinated with B.C.G. vaccine those

contacts who had become Mantoux negative again. From our experience, and the fact that none of these contacts having a negative reaction following B.C.G. vaccination, have developed pulmonary tuberculosis, we have felt that the degree of protection by B.C.G. vaccination did not depend entirely on the degree of sensitivity shown by the Mantoux test. We therefore feel that there is now no need for re-vaccination in negative reactors following orthodox B.C.G. vaccination. It certainly appears that even when in a B.C.G. vaccinated contact the follow-up Mantoux test is still negative, there is still some degree of immunity.

It is quite a different problem when the initial Mantoux test is found to be positive, particularly in children entering school for the first time. In such cases there are ample grounds for investigating the whole of the child's family, and in certain cases perhaps for instituting prophylactic chemotherapy. At present children are Mantoux tested in school at the age of 13, and the negative reactors are given B.C.G. vaccination; positive reactors at that age should also continue to be referred for x-ray examination.

Bronchial Carcinoma

Table 4 shows the number of new cases of bronchial carcinoma found at the chest centre during 1968. One should again note the small number of cases accepted for surgery.

Table 4

East Cumberland	Males	Females	Total
New cases ...	20	6	26
Admitted for surgery	—	—	—
 Carlisle City			
New cases ...	20	9	29
Admitted for surgery	2	—	2
 North Westmorland			
New cases ...	1	1	2
Admitted for surgery	—	—	—

The five-year survival rate after surgery remains low and is not greater than 4%. Indeed, although great advances have been made in the past 20 years in many aspects of medicine and surgery, there has been little advance in the prognosis and treatment of cancer of the lung.

In many areas now it is the most common visceral cancer in men, and there has undoubtedly been, over the last 20 years, an actual increase in the incidence of the disease. The small number of cases found at the chest centre here during 1968 is, I think, purely fortuitous, and the figures for the first quarter of 1969 suggest that there has been no actual drop in its incidence. Cancer of the lung now accounts for one in 17 of all male deaths and the mortality throughout England and Wales has risen by an average of 8% per annum.

Over the last ten years we have seen approximately 700 new cases of lung cancer, and the overall pick-up of the disease through the mass radiography unit in this area has been 18%. Approximately half of the total number diagnosed have not been submitted for bronchoscopy as the lesion, when first seen, was so advanced, or the patient's condition so poor, that the diagnosis was purely academic. Our overall five-years survival rate, as far as the chest centre cases go is approximately 3%. I must point out, of course, that all cases of cancer of the lung in this area do not come through the chest centre; many other departments in the hospital service see cases just as we do.

In a disease for which there is not yet any adequate surgical or medical treatment, the approach must be preventive. It is a serious reflexion on the state of medicine today that advances in therapy (and I need only take heart transplants as an example) are applauded by the press and public even when a particular therapy results in no more than keeping a relatively small number of people alive.

Although the association of cancer of the lung with heavy cigarette smoking has been known for years now and has often been mentioned in these reports, there has unfortunately been comparatively few public health measures to counteract this. If,

however, we get an advance in preventive medicine, the public and press take little notice and both continue to invest in as many, if not more, cigarettes than before.

We should naturally like to make a diagnosis of the disease at as early a stage as possible but I must emphasise that even early diagnosis does not generally improve the survival rate after surgery. I do not feel that mortality from cancer of the lung would be reduced greatly by early diagnosis, and I feel that we must wait for the day when adequate chemotherapy of some kind will be available before the prognosis can be improved.

Other Chest Conditions

Chronic Bronchitis

Many cases of chronic bronchitis continue to be seen at the chest centre with, or without, emphysema. Here again, probably the best advice one can give to such patients is to give up smoking cigarettes, and it is surprising how much benefit can accrue to the patient as a result of doing just this. Treatment is largely a question of accurate antibiotic therapy depending on the sensitivity of the organisms in the patient's sputum and well managed physiotherapy.

Asthma

Many cases of asthma are seen at the chest centre. Asthma remains quite a serious condition and is certainly very common in this East Cumberland area. All groups of severity are found, and although uncommon, death can actually occur. Assessment and care of these patients is undoubtedly difficult and full use is made of the services of the physiotherapist in their treatment. Continued care of these patients is essential as even when treatment results in apparent complete cure, the condition is very liable to recur. Admission of the patients to the wards is often necessary, especially in cases of status asthmaticus, when one usually finds that the patient has failed to carry out instructions. As I indicated, treatment can be very difficult, and investigation of such cases can be most time consuming, as there is often an underlying anxiety syndrome with a domestic background. In some cases one has to secure the help of a psychiatrist.

Farmer's Lung

We continue to see many new cases of 'Farmer's Lung'; this now comes under the Industrial Injuries Act. Most cases clear up satisfactorily but should the condition occur in a young farmer or farm-worker, then it would be wise for him to change his occupation.

Bronchiectasis

The number of new cases of bronchiectasis seen during the year is a new low figure of 19. Table 5 gives the total number of cases of bronchiectasis on the Register as at 31.12.68. No cases of bronchiectasis have been submitted for surgery during the year.

Table 5

		Male	Female	Children	Total
East Cumberland	...	62	56	—	118
Carlisle City	...	64	57	—	121
North Westmorland	...	10	4	—	14

Table 6 gives the statistical summary of the work done by the static mass radiography unit at Warwick Road, Carlisle for the years 1966, 1967, and 1968.

Table 6**Statistical Summary of work done at the Static Mass Radiography Unit**

	1968	1967	1966
Miniature films	6259	5726	5635
Referred for clinical examination	360	316	393
Active tuberculosis	3	7	9
Inactive tuberculosis	25	9	13
Bronchiectasis	7	19	20
Neoplasm	15	17	29
Pneumoconiosis	1	—	—
Sarcoidosis	2	3	—
Cardiac conditions	36	29	30
Doctors' cases	2966	2719	2669
Contacts per the chest centre ...	251	59	78
General public	2368	2335	2109
Works personnel	667	613	779

This will be my last report as Consultant Chest Physician to this area. I cannot let this pass without expressing my sincere thanks, not only to the Medical Officers of Health in this East Cumberland area, but to all doctors and colleagues who have made my work so very rewarding.

APPENDIX III

County Council Clinics

Centre		Address	Clinic Services
Alston	...	Cottage Hospital, Alston	Child Welfare, Dental, Chiropody.
Anthorn	...	Welfare Office, ... Anthorn	Child Welfare, Vaccination and Immunisation.
Aspatria	...	St. Mungo's Park, Aspatria	Child Welfare, Dental, Speech Therapy, Vaccination and Immun- isation.
Brampton	...	Union Lane, ... Brampton	Mothercraft, Child Welfare, Chir- opody, Dental, Orthopaedic, Vac- cination and Immunisation.
Broughton	...	Nurse's House, ... Little Broughton	Child Welfare.
Carlisle	...	14 Portland Sq., ... Carlisle	Child Guidance, Dental, Ophthal- mic, Orthoptic, Orthopaedic, Speech Therapy, Cervical Cytology, Chir- opody.
Cleator Moor	...	Ennerdale Rd, ... Cleator Moor	Ante-Natal, Child Welfare, Chirp- ody, Dental, Vaccination and Imm- unisation, Cervical Cytology.
Cockermouth	...	Harford House, ... Cockermouth	Relaxation, Child Welfare, Chirp- ody, Dental, Ophthalmic, Speech Therapy, Vaccination and Immun- isation, Cervical Cytology.
Dalston	...	Victory Hall, ... Dalston	Child Welfare.
Dearham	...	Nurse's House, ... Central Road, Dearham.	Child Welfare.
Egremont	...	St. Bridget's ... Lane, Egremont	Ante-Natal, Child Welfare, Chir- opody, Dental, Vaccination and Immunisation, Speech Therapy.
Frizington	...	Council Chambers, Frizington	Ante-Natal, Child Welfare, Vac- cination and Immunisation.

Centre		Address		Clinic Services
Houghton	...	The Village Hall, Houghton	...	Child Welfare, Vaccination and Immunisation.
Hunsonby	...	The Village Institute, Hunsonby	...	Child Welfare, Vaccination and Immunisation.
Keswick	...	13-15 Bank St., Keswick	...	Relaxation, Child Welfare, Dental, Ophthalmic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Longtown	...	Esk Street, Longtown	...	Child Welfare, Dental, Orthopaedic, Vaccination and Immunisation.
Maryport	...	24 Selby Terrace, Maryport	...	Ante-Natal, Child Welfare, Child Guidance, Speech Therapy, Vaccination and Immunisation, Cervical Cytology (at Surgery), Chiropody.
Millom	...	18, St. George's... Road, Millom	...	Ante-Natal, Child Welfare, Child Guidance, Dental, Speech Therapy, Vaccination and Immunisation, Cervical Cytology, Family Planning.
Nenthead	...	Overwater Nenthead	...	Child Welfare.
Penrith	...	Brunswick Square, Penrith	...	Mothercraft, Child Welfare, Dental, Family Planning, Hearing Therapy, Vaccination and Immunisation, Psychiatric, Speech Therapy, Orthopaedic, Orthoptic, Cervical Cytology, Chiropody.
Scotby	...	The Village Hall, Scotby	...	Child Welfare, Vaccination and Immunisation.
Seascale	...	Gosforth Road, Seascale	..	Child Welfare, Dental, Chiropody, Vaccination and Immunisation.
Seaton	...	Miners' Welfare Hall, Seaton	..	Child Welfare, Vaccination and Immunisation.
Skinburness	...	R.A.F. Hut	.	Child Welfare.
Thornhill	...	Community Centre, Thornhill.	..	Child Welfare.

Centre		Address		Clinic Services
Thursby	...	The Church Hall, Thursby		Child Welfare.
Wetheral	...	The Village Hall, Wetheral		Child Welfare, Vaccination and Immunisation.
Whitehaven Flatt Walks		Flatt Walks, Whitehaven	..	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, School, Speech Therapy, Vaccina- tion and Immunisation, Cervical Cytology.
Mirehouse	...	Dent Road, Mirehouse, Whitehaven	.	Ante-Natal, Child Welfare, Dental, Vaccination and Immunisation.
Woodhouse		Woodhouse, Whitehaven	..	Ante-Natal, Child Welfare, Vac- cination and Immunisation.
Wigton	...	Birdcage Walk, Wigton	.	Ante-Natal, Child Welfare, Chir- opody, Dental, Orthopaedic, Speech Therapy, Vaccination and Immun- isation, Cervical Cytology.
Workington	...	Park Lane, Workington	.	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, School, Speech Therapy, Cervical Cytology.
Salterbeck	...	Holden Road, Salterbeck, Workington	..	Ante-Natal, Child Welfare, Dental, Cervical Cytology, Vaccination and Immunisation, Chiropody.

